Assessment Application
Washington State University Psychology Clinic

Today’s Date ___________________________ Client ID # ________________

Client Name: ________________________________________________________________
(First, Middle, Last)

Address: _______________________________________ Phones: Cell: ______________________

City: ___________________________ State: ______ Zip: _______ Work: _______________________

Occupation: ___________________________ Message: _________________________________

Birth date: __________________ _______ Age: _______ Gender: ___________________________

If we need to contact you, where would you prefer we leave a message? ____ Cell ____ Work ____ Message

Name of Individual with whom we can leave a message: ______________________________________

Have you ever been a uniformed member of any branch of the US Military (Active Duty, Guard or Reserve)?
_____Yes _____ No Are you a family member (Spouse, Parent, Child) of a Veteran? _____ Yes _____ No

How did you hear about the Psychology Clinic? __________________________________________________________________________

Were you referred? ______ If so, by whom? __________________________________________________________________________________

Type of Assessment You Are Seeking: ________________________________________________

_____ Learning Disability _____ Attention Deficit Disorder _____ Neuropsychological _____ Psychological

Other (please describe): ______________________________________________________________

Race/Ethnicity: _________________________________________________________________

_____ African American/Black/African _____ Arab American/Arab/Persian

_____ American Indian or Alaskan Native _____ Native Hawaiian or Pacific Islander

_____ Asian American/Asian _____ Caucasian/White/European American

_____ East Indian _____ Multi-Racial

_____ Hispanic/Latino/Latina

_____ Other (Please specify) _______________________________________________________

What is your country of origin? ____________________________________________________

Relationship Status: _____________________________________________________________

_____ Single _____ Separated _____ Civil Union, domestic partnership or equivalent

_____ Married _____ Widowed _____ Engaged

_____ Divorced

STUDENT INFORMATION
Name of School: ___________________________ Student ID# ________________

Current GPA: ___________ High school GPA: ___________

SAT Verbal Score: ___________ SAT Math Score: ___________
In grade school and high school, which classes did you like?

Have you ever been placed in special education classes? _____ YES _____ NO
If yes, please describe:

Were you ever held back a grade? _____ YES _____ NO
If yes, which one?
List the subjects in which you are having difficulty:

Please describe your current difficulties:

Do you experience any difficulties understanding spoken or written language? _____ YES _____ NO
If yes, please describe:

Have you ever experienced a head injury, loss of consciousness, or seizures? _____ YES _____ NO
If yes, please describe:

Did you experience any complications at birth (e.g., cord around neck)? _____ YES _____ NO
If yes, please describe:

Did you reach developmental milestones within normal limits (e.g., learning to walk, talk)? _____ YES _____ NO
If no, please describe:

Have you ever been tested for intelligence or achievement in the past? _____ YES _____ NO
If yes, what type of testing?
Describe your current sources of stress:

Do you have a chronic medical condition/illness (e.g., Diabetes, hypertension)? _____ YES _____ NO
If yes, please describe:
Are you taking any medications at this time? _____YES   _____NO

If yes, please list (include over-the-counter medications):
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Have you ever abused alcohol or illicit drugs? _____YES   _____NO

Are you currently abusing alcohol or illicit drugs? ______YES ______NO

Do you have difficulty remembering things? _____YES _____NO
If yes, please describe: ______________________________________________________
__________________________________________________________________
__________________________________________________________________

Do you have difficulty hearing, or have poor vision and wear glasses? _____YES _____NO
If yes, please describe: ______________________________________________________

Is there a deadline by which this testing needs to be completed? _____YES _____NO
If yes, by when? ______________________________

Please place check marks by all of the times you or your child/ward are available to attend therapy sessions:

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:00 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Closed</td>
</tr>
<tr>
<td>4:00 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Closed</td>
</tr>
<tr>
<td>5:00 pm</td>
<td></td>
<td></td>
<td></td>
<td>Closed</td>
<td>Closed</td>
</tr>
<tr>
<td>6:00 pm</td>
<td>Closed</td>
<td>Closed</td>
<td>Closed</td>
<td>Closed</td>
<td>Closed</td>
</tr>
<tr>
<td>Print Client's Name</td>
<td>Client’s date of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Signature (If age 13 or older)</td>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If client is under the age of 18, please also complete the following:*

<table>
<thead>
<tr>
<th>Print Parent/Guardian/Authorized Adult’s Name</th>
<th>Relation to Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian/Authorized Adult Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
CONSENT FOR TREATMENT

Psychology Clinic
Washington State University
P.O. Box 644820
Pullman, WA 99164-4820
509-335-3587  Fax: 509-335-1030

Services
The Washington State University Psychology Clinic (Clinic) is a mental health service and training center that provides the following services: a) Psychological assessment (neuropsychological testing, psychological evaluation, and personality assessment); and b) therapy for individual adults, children and parents, and veterans and their family members. Assessments are provided to help clients identify specific areas of cognitive strength, difficulty, and concern, as well as diagnose specific conditions (e.g., ADHD) that are consistent with clinical and cognitive data. Therapy is a cooperative process in which a therapist and client meet regularly to clarify issues of concern, discuss options, and work toward meeting goals by developing effective problem-solving skills and greater self-understanding. Parents/guardians/authorized adults will participate in an initial interview with a minor client. The initial interview is a process designed to gather specific information about the minor’s needs. Following the initial interview, a treatment plan will be developed, and therapy will begin shortly thereafter.

If you are receiving therapy services, you will be asked to complete a brief (5-10 minute) questionnaire at the beginning of each session to update information important to you and your therapist, including your assessment of how therapy is going and how you feel about your relationship with your therapist. Your therapist may share the results of this questionnaire with you at the beginning of each session so that the two of you can make sure you are addressing your most important concerns, making progress toward your goals for treatment, and attending to issues that might be interfering with your work together. Feedback can also help your therapist improve his or her clinical skills, an important part of the training mission of the Clinic. (Note: Clients age 13 and older will complete their own assessment of services. Parents/guardians/authorized adults will complete assessments for clients under the age of 13.)

Staff
Doctoral students in the Clinical Psychology Program at WSU, under the close supervision of licensed psychologists in the Department of Psychology, provide the majority of therapy and assessment services to the community.

Attendance
The Clinic may suspend or terminate therapy or assessment services in response to two consecutive missed appointments or a pattern of excessive cancellations and/or missed appointments. You must call (509) 335-3587 to cancel appointments at least 24 hours in advance. Missed therapy appointments or late cancellations (less than 24 hours prior to your appointment) are charged at the rate you established for services at the beginning of treatment. Clients who fail to attend an initial assessment appointment will have their names moved to the bottom of the assessment waiting list. Subsequent assessment appointments that are missed or cancelled late will be charged a $25.00 fee. Please Initial ______

Payment
Payment is due prior to services being rendered. We accept payment by cash, check, and money order. We also accept MasterCard and Visa. If you choose to pay for services using your credit card, we encourage you to arrange to make one larger payment per month to help us reduce paperwork. You can do this by talking with your therapist or the Patient Services Coordinator regarding when you want to pay each month. Late Payments: If you are unable to provide payment for two consecutive sessions, your
treatment may be suspended until payment is received unless you have already made other arrangements with us.

**Scheduling & Cancellations**
Appointments are scheduled directly by therapists or the Patient Services Coordinator and can be arranged during business hours. Messages regarding treatment, billing, and cancellations can be left at (509) 335-3587 at any time.

**After Hours, Weekends, Holidays**
*If you feel you or your child are in crisis:* Please call 911, your primary care physician, or go to your local emergency room. Crisis hotlines: Psychology Clinic crisis line (800-663-2810), Alternatives to Violence 24-hour crisis lines in Pullman (509-332-4357) and Moscow (208-883-4357).

**Parking**
All parking spaces on campus require a permit. Illegal parking fines are costly. The Clinic will provide 60-minute parking for therapy clients in the Smith Center for Undergraduate Education Parking Garage. Contact the clinic at 509-335-3587 with any questions regarding parking.

**Confidentiality**
Clients have privileged communication with a therapist under state and federal law [RCW 18.83.110]. We understand that personal health information is very sensitive. We will not disclose a client’s personal information to others without written consent, unless the law requires or permits us to do so [RCW 70.02.230]. You will receive a copy of our Notice of Privacy Practices, which outlines in detail how we use and disclose your protected health information.

**Minors, Ages 13-17.** Under Washington state law, minors, ages 13-17, can request and receive outpatient mental health treatment without parental consent [RCW 71.34.530]. Although a minor’s treatment records are confidential, the records can be disclosed to the minor’s parent if the parent requests the record. We will not disclose a minor’s treatment records without the written consent of either the minor or the minor’s parent, unless the law requires or permits us to do so [RCW 70.02.240].

**Reporting Requirements/Authorizations.** We disclose information to the appropriate authorities under the following conditions:

a) To report a reasonable belief that a child has suffered abuse or neglect [RCW 26.44.030]. For reporting purposes, a child is anyone under the age of 18 [RCW 26.44.020].

b) To report a reasonable belief that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred [RCW 74.34.035 and RCW 5.60.060(9)(d)].

c) To prevent or minimize an imminent danger to the health or safety of the patient or any other person [RCW 5.60.060(9)(e)].

d) To comply with a court order or subpoena.

If you have any questions or concerns about the reporting criteria, please talk with your therapist.

**Supervision & Training.** The Clinic is staffed by graduate student therapists in the Clinical Psychology Ph.D. program under the direct supervision of licensed faculty members. For the purpose of supervision, training, and quality assurance, supervisors will review your medical records and recordings of your therapy to assess the performance of our student therapists and to ensure you are receiving the appropriate treatment. Therapists may also consult with one another regarding your therapy.

**Audio/Video (A/V) Recording**
Faculty supervisors need to review the treatment our student therapists provide to clients. For the purpose of supervision, training, and quality assurance, clients’ treatment sessions will be A/V recorded on a
secure, internal network. A/V recorded material is confidential and has the same security protections as other electronic records. A/V recorded material is password protected and is only accessed by authorized therapists and supervisors. A/V recorded material is erased at the end of supervision use, which typically occurs within two weeks of the treatment session. You will be asked to sign a separate release authorizing A/V recording of your treatment sessions. Your decision to authorize A/V recording of treatment sessions is voluntary, and you may withdraw your consent for continued A/V recording at any time.

**Paper & Electronic Records**

Written and electronic records are kept of the services provided to clients. Written records are stored in locked file cabinets within a locked room in the Clinic and are destroyed in a confidential manner after a period of ten years of inactivity. Electronic records are maintained on a secure, internal file server that is stored in a physically secure facility. The file server is also password and firewall-protected. You may request a copy of your medical records as outlined in our Notice of Privacy Practices.

**Right to Refuse Treatment**

You have the right to refuse treatment. If you consent to treatment, you have the right to withdraw your consent and discontinue treatment at any time. If you have questions or concerns about confidentiality, therapy, assessments, procedures, or any other aspect of the services you or your child/ward receive, please speak with your therapist, the Clinic Director, or the Privacy Officer. If you become dissatisfied with your treatment and would like a referral elsewhere, the Clinic will assist you with a referral to another therapist or agency.

**Treatment Risks, Benefits & Alternatives**

**Possible Risks.** Clients undergoing therapy might experience the following side-effects and other known risks associated with mental health treatment: Because therapy often involves discussing unpleasant aspects of your life, you may sometimes experience uncomfortable feelings such as sadness, anxiety, guilt, anger, frustration, loneliness, or helplessness. You may recall unpleasant memories or experience flashbacks to traumatic events. These feelings and memories may, for a time, bother you at work or in school. Making changes in your thoughts, feelings, and behaviors may feel disorienting or frightening at first and is sometimes disruptive to your important relationships. This can be stressful and may affect sleep, appetite, energy, and ability to concentrate at times. You may be asked to complete homework assignments that take time and effort. It is also possible that despite the best efforts made by you and your therapist, you may not achieve the results you want. Change may also require more time than you initially intended. It is important that you carefully consider whether these potential risks are worth the possible benefits of making changes in your life at this time.

If you are participating in psychological or neuropsychological assessment, you may experience some fatigue as a result of the time required and your effort to perform your best on tests. You may achieve results that are unexpected or disappointing to you.

**Possible Benefits.** Clients undergoing therapy might experience the following known benefits associated with mental health treatment: You may experience significant reductions in symptoms such as depression or sadness, anger, anxiety, hopelessness or helplessness. Therapy often leads to more satisfying relationships, more effective coping skills, improved stress management, solutions to specific problems, and significant reductions in feelings of distress. Life satisfaction often improves, along with performance at work or school. Personal goals and values may become clearer. Therapy may also contribute to feelings of self-acceptance and confidence in your ability to achieve your goals. There is no guarantee that you will experience these benefits as a result of your participation in therapy; however, you will be better equipped to make the life changes you desire with the help and support that therapy can provide.
The benefits of assessment may include more accurate diagnosis of mental health disorders, which helps you and your therapist develop a more effective treatment plan. You may learn about aspects of your personality, thoughts, feelings and behaviors that will help you make the changes you desire. Neuropsychological assessment may identify the presence of specific learning disorders, memory problems, or other disorders, which can help you locate specialized treatment or receive school or work accommodations.

**Alternatives to Therapy Treatment.** Reasonable alternatives to therapy include: Psychiatric consultation and psychotropic medication to address symptoms related to depression, anxiety, bipolar disorder, schizophrenia and other mental health concerns when research supports the efficacy of such medication; self-help support groups such as Alcoholics Anonymous; psycho-educational groups that focus on specific concerns, such as anger management, social skill development, or insomnia; or self-help books and on-line programs.

I understand and accept the possible risks and benefits associated with mental health treatment. I also understand the available alternatives to treatment. If I have any questions or concerns about the risks, benefits, and/or alternatives to treatment, I will discuss them with my therapist. **Please initial _____**

**Termination/Transfer of Care**
The Clinic reserves the right to terminate treatment if it becomes evident to the Clinic Director that the client: a) has care requirements that exceed the capabilities/expertise of a student therapist in the clinical training program; b) will not benefit from continued service; c) no longer needs the services of the Clinic; or d) missed two consecutive sessions or has a pattern of excessive cancellations or missed appointments. In the case of termination of care, the Clinic will provide you with a list of mental health providers in the community from whom you can seek assistance. **Please initial _____**

**Consent for Services**
I understand and agree to the conditions described in this document and consent to treatment. I agree to pay for the services received at the rate indicated on the Fee Worksheet. I have received a copy of this consent form.

Print Client’s Name

Client’s Date of Birth

Client Signature (if age 13 or older)

Date

*If the Client is under the age of 18, please also complete the following:*

Print Parent/Guardian/Authorized Adult’s Name

Relation to Client

Parent/Guardian/Authorized Adult Signature

Date
Appendix A: WSU Telehealth Consent Form
WSU PSYCHOLOGY CLINIC ADDENDUM
Informed Consent for Telemental Health Services

This Informed Consent for Telemental Health Services is an addendum to the standard consent for care agreement with the WSU Psychology Clinic. All aspects of our general WSU Psychology Clinic consent form (including the legally-mandated exceptions to confidentiality) remain in effect if you choose to receive telemental health services.

Telemental Health (TMH) refers to counseling services provided remotely using telecommunications technologies such as secure video conferencing or telephone. TMH Services are conducted and documented in a confidential manner according to applicable laws and professional and ethical standards consistent with in-person services.

One of the benefits of TMH is that the client and clinician can engage in services without being in the same physical location. A growing body of research indicates that TMH can be an effective mode of treatment with benefits similar to face-to-face-therapy. However, like any other form of treatment, the results of TMH cannot be guaranteed.

Please review the information below to help you make your decision regarding whether or not you (or your child) would like to consent to receive psychological services through TMH.

- Although we are using technology that has been approved for delivering secure telehealth services, there are some inherent risks to privacy and confidentiality anytime that technology is used. By consenting to TMH services, you are indicating that you understand that risk. Additional questions about this risk should be discussed with your clinician.

- As stated in our general consent form, we are a training clinic and our therapists are students enrolled in our doctoral clinical psychology program who are supervised in their work by licensed clinical psychologists. For the present time, due to statewide stay-at-home orders, student clinicians will be providing services from their own home in a private location using a secure WSU-owned computer. During this time, faculty supervisors may choose to join a zoom session in silent mode to supervise your student clinician. Zoom TMH sessions are not to be recorded. Once student clinicians are able to conduct TMH sessions from the Psychology Clinic, sessions will be recorded and reviewed using the same technology that is used for in-person sessions in the Clinic.

- Clinicians will take steps to protect your privacy by ensuring that they have a private and secure space to conduct your session. You are responsible for taking steps to protect your privacy during sessions as well, including finding a space that is private, quiet, and minimizes distractions (e.g., turn off cell phones, close other programs on your computer).

- We will be using a “HIPAA compliant” version of Zoom, a cloud-based video conferencing tool for TMH sessions. Zoom requires the use of a browser but does not require any software download. However, you will need to set up a free Zoom account for your sessions. This can be done by visiting www.zoom.us.
o In order to use Zoom to receive TMH services with your provider, you will need access to Internet service. You are advised to use a secure internet connection. For best picture and audio quality, a hardwired connection (via LAN cable) rather than a wireless one should be used if possible. If you do choose to use Wi-Fi it is best to use one that is secure, private and password protected. It is not appropriate to use public or shared Wi-Fi. Headphones add additional security.

o Sessions could be disrupted, delayed, communications distorted, or poor transmission quality due to technical failures, and/or telecommunication service availability or outages. You and your clinician will make plans at the onset of your TMH service through Zoom for how you will communicate if you experience technological problems (i.e., rescheduling times, checking in by phone).

o You will need to participate in making a plan for mental health crises, and medical emergencies. In addition to having your current phone number where you can be reached, before the start of each session, we will need to know the address of where you are physically located. Furthermore, your therapist will work with you to develop a safety plan, which includes identifying one or two emergency contacts in your area. You will need to provide permission for your provider to communicate with these emergency contacts about your care should an emergency arise.

o For the months of May through the end of July 2020, there will be no charge for TMH services, although standard fees apply for assessment services. After this time period, you will be responsible for the costs of TMH services (at the same rate as your usual rate). You are asked to pay for therapy sessions by calling the WSU Psychology Clinic during business hours and prior to your session to provide a credit card number. Paying for 3-4 sessions in advance is recommended.

o It is possible that receiving TMH services will not be an effective form of therapy for you, and that you and your provider may have to cease TMH services for reasons including, but not limited to: heightened risk of harm to oneself or others; lack of access to, or difficulty with, communications technology; significant communications service disruptions; and/or need for more intensive services. In these cases, your clinician will provide referrals to other providers or clinics in the area. You may also be able to receive in-person services when the WSU Psychology Clinic resumes in-person operations.

o You are only eligible for TMH services as long as you are physically located in the state of Washington. State licensure laws prevent your clinician from being able to provide services if you are located in another state at the time of the session. If you anticipate that you will not be physically located in the state of Washington during a planned session, you are responsible for letting your therapist know. Your therapist can provide you with referrals for continued services in your local area.
o TMH services are being offered temporarily in response to a public health emergency. In consenting to telehealth services, you understand that it is likely services will move back to an in-person format when the WSU Psychology Clinic resumes in-person operations. We are unable to predict at this time if we will be able to continue TMH services. Should you wish to continue with this format, your clinician may refer you to other providers that regularly provide TMH services.

o Communication between TMH sessions is possible over the WSU Psychology Clinic’s telephone at (509) 335-3587. Please leave a voice mail if you have questions. We will respond to your phone call in a timely manner. If you need to cancel your TMH session, please do so 24 hours in advance to avoid no-show fees.

o Zoom links for your TMH sessions will be embedded in an email sent to your email address from CHADIS.

I have been informed of and understand the risks and procedures involved with TMH services. I agree to the terms listed above and I hereby voluntarily consent to the use of videoconferencing technology for psychological services with my provider. I agree that the WSU Psychology Clinic should not be held liable in the event that any outside party passes technology security safeguards and accesses personal or confidential information. This consent will last for the duration of the relationship with this clinic; I can withdraw my consent for psychological services at any time, and the WSU Psychology Clinic will work with me to find a suitable alternative.

If you understand and consent to the risks and policies detailed above for TMH services, you can initiate these services with your clinician by typing your name or the child patient’s name and date of birth, and parent/guardian’s name, if applicable, as well as the date below.

Patient Name:_________________________________________ Date of Birth: ______________________________

Parent/Guardian Name (if applicable):__________________________________________

Signature of Patient or Parent/Guardian:_________________________ Date: ________________

Signature of Provider:______________________________ Date: ________________
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

Psychology Clinic
Washington State University
P.O. Box 644820, Pullman, WA 99164-4820
509-335-3587 Fax: 509-335-1030

The Washington State University Psychology Clinic (Clinic) is required by law to maintain the privacy of your protected health information (PHI) [RCW 18.83.110, RCW 70.02.020, and RCW 70.02.230]. This Notice tells you how we use and disclose your PHI. This Notice also outlines your rights and our legal obligations under the Health Insurance Portability and Accountability Act (HIPAA). This updated Notice is effective as of its date of revision noted below.

Protected Health Information

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Clinic at (509) 335-3587. [RCW 70.02.120]

The privacy practices outlined in this Notice apply to your health information, created or received by the Clinic, that identifies you and relates to your past, present or future physical or mental condition. Your PHI includes your treatment plan, test results, diagnoses, health information from other providers, and financial information that could identify you. The information often contained in your medical record serves as a means of communication among the many health professionals who contribute to your care.

Uses and Disclosures

The law allows us to use and disclose your PHI for purposes of treatment, payment, and health care operations. We may also disclose your PHI without your written authorization when required or authorized by law. Other uses and disclosures will be made only with your written authorization, which you may revoke at any time, except to the extent that we have already acted on your authorization.

Treatment. Your therapist will record your information in your medical record and will discuss your health with other practitioners to help decide what treatment or assessment is right for you.

Payment. If we are treating you through a contract with the State of Washington Department of Veterans Affairs or the State of Washington Department of Social and Health Services, we will give them information about you so they can pay for your services.

Healthcare Operations. The Clinic is a mental health service, training, and research center operated by the Department of Psychology. The Clinic is staffed by graduate student therapists in the Clinical Psychology Ph.D. program under the direct supervision of licensed faculty members. We will review your medical records to assess the performance of our student therapists and to ensure you are receiving the appropriate treatment. We can contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.

Disclosures Required or Authorized by Law. The Clinic will comply with legal notification requirements and authorizations, which include the following circumstances:

- To report a reasonable belief that a child has suffered abuse or neglect [RCW 26.44.030]. For reporting purposes, a child is anyone under the age of 18 [RCW 26.44.020].
- To report a reasonable belief that abandonment, abuse, financial exploitation, or neglect of a
vulnerable adult has occurred [RCW 74.34.035 and RCW 5.60.060(9)(d)].

- To prevent or minimize an imminent danger to the health or safety of the patient or any other person [RCW 5.60.060(9)(e)].
- To comply with a court order or subpoena.

**Your Rights**

You have the right to request restrictions on certain uses and disclosures of your PHI; however, we are not required to agree to your requested restriction. You have the right to receive confidential communications about your PHI by reasonable alternative means and locations. You have the right to inspect and receive a copy of your PHI, except for psychotherapy notes and other exceptions provided by law. (Charges for copies of your medical record will apply.) You have the right to request an amendment to your PHI to correct any errors or omissions. You have the right to receive an accounting of disclosures of your PHI, except for disclosures exempted by law. You have the right to receive a paper copy of this Notice.

**Our Duties**

The Clinic is required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice and to make the new provisions effective for all PHI we maintain. Any revisions to this Notice will be posted online and in a clear and prominent location at the Clinic and you will be requested to read and sign the revised version of the Notice of Privacy Practices.

**Complaints**

You may complain to the Clinic and to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. The Clinic will not retaliate against you for filing a complaint. If you have questions, want more information, or want to report a problem about the handling of your PHI, you may contact the WSU Psychology Clinic Privacy Officer at:

- P.O. Box 644820
- Pullman, WA 99164-4820
- (509) 335-3587

You may contact the U.S. Department of Health and Human Services Office of Civil Rights at:

- 200 Independence Avenue SW
- Washington DC 20201
- (877) 696-6775
- [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)

**Acknowledgment of Receipt**

I acknowledge that I have received a copy of this Notice of Privacy Practices.

---

Print Client's Name ____________________________  Client’s date of birth ____________________________

Client Signature  (If age 13 or older) ____________________________________________________________  Date ____________________________

*If client is under the age of 18, please also complete the following:*

Print Parent/Guardian/Authorized Adult’s Name ____________________________  Relation to Client ____________________________

Parent/Guardian/Authorized Adult Signature _____________________________________________________  Date ____________________________
Consent to Audio/Video (A/V) Recording

Psychology Clinic
Washington State University
P.O. Box 644820
Pullman, WA 99164-4820
509-335-3587 Fax: 509-335-1030

The Washington State University Psychology Clinic is a mental health service and training center for the Department of Psychology. Services are provided by student therapists in the Clinical Psychology doctoral (Ph.D.) program under the close supervision of licensed faculty members.

For the purpose of supervision and training, your or your child/ward’s treatment sessions will be A/V recorded. A/V recorded material is confidential. It is maintained on a file server that is stored in a physically secure facility. The file server is also password and firewall-protected. A/V recorded material is erased at the end of supervision use, which typically occurs within two weeks of the treatment session.

Authorization

I hereby authorize the A/V recording of my, or my child/ward’s, treatment sessions. My decision to authorize A/V recording of treatment sessions is voluntary. I understand that I can withdraw my consent for continued A/V recording at any time.

Print Client's Name ___________________________ Client’s date of birth _____________

Client Signature (If age 13 or older) ___________________________ Date _____________

If client is under the age of 18, please also complete the following:

Print Parent/Guardian/Authorized Adult’s Name ___________________________ Relation to Client _____________

Parent/Guardian/Authorized Adult Signature ___________________________ Date _____________

Revised 1/2014
Study Title: Washington State University Psychology Clinic Research Database

Researchers: Dr. Walter Scott, Director of the WSU Psychology Clinic (509-335-3588)

YOUR CHOICE TO PARTICIPATE OR NOT IN THIS RESEARCH STUDY WILL NOT AFFECT YOUR ACCESS TO SERVICES

This consent form is only pertaining to your participation in the research project, which is not related to your clinical treatment. Your consent to be treated at the Psychology Clinic at Washington State University requires a separate consent form.

You are being asked to allow information we collect about you as part of our standard clinical care to be stored in a clinical research database. This information will be stored in a manner that will be stripped of identifiers except for the subject ID code, so that your name or other personally identifying information would not be linked to your data. We will use a research ID number, and will aggregate your responses with other client responses to further protect your privacy.

This clinical research database is being overseen by Dr. Walter Scott, a Professor in the Washington State University (WSU) Psychology Department, who is also the Director of the WSU Psychology Clinic.

This form explains this clinical research database in more detail and your part in it if you decide to join the study. Please read the form carefully, taking as much time as you need. Ask the clinic staff to explain anything you don’t understand. You can decide not to join the study. If you join the study, you can change your mind later or quit at any time. There will be no penalty or loss of services or benefits if you decide to not take part in the study or quit later. This study has been approved for human subject participation by the Washington State University Institutional Review Board.

You cannot take part in this study if you are under 18, cannot communicate well in English, or do not consent to participate.

What is this research study about?

As part of your standard clinical treatment/assessment, you will be asked to complete various measures. Completion of these measures is critical to enabling us to provide you the best level of care. Your completion of these measures is considered a non-
research procedure; that is, it is just a standard part of our normal clinical practice. And you will be able to complete these measures whether you agree to participate in this study or not.

If you agree to be in this research study, however, we would store your data stripped of identifiers except for the subject ID code in a secure clinic research database. Our Patient Services Coordinator, Rachelle Simons, will assign a research participant ID code to each consenting participant. There will be a separate, password protected file stored on a secure, password-protected computer in a locked office at the WSU Psychology Clinic that will link the research participant ID code with client identifiers. Only Rachelle Simons, the Patient Services Coordinator, Walter Scott, the Clinic Director, and Conny Kirchhoff, the Assistant Director, will have access to this master list linking client’s data with identifiers. The key will be maintained indefinitely. The information kept in the clinic research database will contain no personally identifying information other than the randomly assigned subject ID. We refer to information that has had personally identifying information removed, as “de-identified.” Signing this consent form will grant Clinic researchers access to your data stripped of identifiers except for the subject ID code that you provide as part of routine clinical care. Clinic research that utilizes your archived information will have no impact on the type and/or duration of services you receive at the Psychology Clinic.

The clinical research database would be available to WSU Psychology faculty and graduate students for various research questions once they obtained appropriate approval from the WSU IRB. Although we can’t tell you exactly what these research questions will be, in general, they will be questions that will help the researchers better understand mental health problems, how to best measure and treat those problems. You will not be re-contacted for permission to have your data used by these individual researchers. Our overall goal is to improve the psychological treatments and services we provide at the WSU psychology clinic as well as those that are provided by the mental health profession in general.

What will I be asked to do if I am in this research study?

If you take part in the study, you won’t be asked to do anything different than if you were not in the study. Your consent to this research project will just allow us to store your data collected as part of our normal clinical services for future research. You will not be asked to provide more time or effort that is not already part of standard Psychology Clinic procedure (e.g., completing an application, self-report measures, and the diagnostic interview). In other words, participating in the research project requires you to only provide the consent to researchers to use your data stripped of identifiers except for the subject ID code, but not any extra time or effort.

It should be noted that the clinic routinely records therapy sessions on videos. However, these videos are used for supervisory purposes in the doctoral training program.
in clinical psychology ONLY, are destroyed after one month, and would never be made available to researchers. These recordings are not associated with any procedures in this proposal.

As in all psychotherapy and psychological assessments, some of the questions in the questionnaires you will be asked to complete are personal and could cause some discomfort. However, this information is gathered as part of standard Psychology Clinic procedure, and would be collected regardless of your consent to allow this information to be archived, stripped of identifiers except for the subject ID code, and used by Clinic researchers.

You may stop your participation in the clinic research and withdraw consent at any time by notifying your therapist or the clinic that you wish to do so. If at any time you decide to withdraw consent for participating in this study, none of the data you provided will be kept in the clinic research database.

Are there any benefits to me if I am in this study?

There is no direct benefit to you from being in this study. Although granting Clinic researchers access to your archived information, stripped of identifiers except for the subject ID code, will not have a direct benefit for your own treatment, there are important benefits to society in general. The benefits include increased knowledge of mental disorders, psychotherapy treatment, and psychological assessment, which may lead to more effective psychological services for future clients. A better understanding of psychological difficulties and the variables affecting treatment, compliance, and effectiveness is important for the continuing advancement of psychological science and clinical interventions. Additionally, the information you are granting access to has the potential for better informing our knowledge of people seeking psychological services.

Are there any risks to me if I am in this study?

Granting consent for your Clinic information to be archived and potentially used for research purposes has a small risk of loss of confidentiality your data in the research database will be linked to a research participant id code. But this risk is substantially reduced as the master key linking the research participant id code is accessible only to the clinic administrators and is stored in a password-protected file on a computer in a locked clinic room.

Otherwise, it as imposes no discomfort or risks beyond those experienced in everyday life or in psychotherapy in general. As in all psychotherapy, some things you discuss may cause you to feel strong emotions, including negative ones. Similarly, some of the questions in the questionnaires you will be asked to complete are personal and could cause some discomfort. However, this information is gathered as part of standard Psychological Clinic procedure, and would be collected regardless of your consent to allow this information to be archived, stripped of identifiers except for the subject ID
code, and used by Clinic researchers.

If you choose not to consent, this information will be collected as part of your routine clinical care, but will not be made available to investigators in any form at any time. Choosing not to consent will not affect your treatment in any way.

**Will my information be kept private?**

The data for this study will be kept confidential to the extent allowed by federal and state law. No published results will identify you, and your name will not be associated with any findings. In the event of discovery of imminent harm to the participant, or abuse of child or vulnerable people (e.g., elderly, or disable person) during a client’s treatment, the condition would be treated as per best practices in clinical psychology by the treating clinician, regarding reporting to appropriate authorities.

All of the information you provide will remain confidential in accordance with standard Psychology Clinic policies. Information pertaining to your treatment that would be collected as part of normal clinical procedures will be stored and secured, as it would regardless of your participation in this study.

As part of standard procedure, the information you provide will be matched with a 10-digit identifier. Researchers will not have access to your identifying information.

The Office of Human Research Protections in the U.S. Department of Health and Human Services, and the Institutional Review Board at the Washington State University may review records related to this project. The results of this study may be published or presented at professional meetings, but the identities of all research participants will remain anonymous in these instances.

As part of standard Psychological Clinic procedure, all therapy sessions are videotaped for supervision and training purposes. However, researchers will not have access to video or audiotapes under this agreement. This consent does not include permission to access video/audio recordings.

**Are there any costs or payments for being in this study?**

There will be no costs to you for taking part in this study.

**Who can I talk to if I have questions?**

If you have questions about this study or the information in this form, please contact the researcher (Dr. Walter Scott, walter.scott@wsu.edu, 509-335-3588, Rm 364 Johnson Tower, PO BOX 644820, Pullman, WA 99164-4820), who is also the Director of the WSU Psychology Clinic. If you have questions about your rights as a research participant, or would like to report a concern or complaint about this study, please contact the
What are my rights as a research study volunteer?

Your decision to allow access to your Clinic data for research purposes is voluntary. You can withdraw your consent at any time, at which point all your data will be removed from the clinic research database. Refusal to allow access to your Clinic data or withdraw your consent will involve no penalty or loss of services/benefits that you would receive otherwise. If you choose to withdraw your consent, you will be able to continue treatment at the Psychology Clinic.

What does my signature on this consent form mean?

Your signature on this form means that:
• You understand the information given to you in this form
• You have been able to ask the researcher questions and state any concerns
• The researcher has responded to your questions and concerns
• You believe you understand the research study and the potential benefits and risks that are involved.

Statement of Consent

I give my voluntary consent to take part in this study. I will be given a copy of this consent document for my records.

_________________________________________  ______________________
Signature of Participant                      Date

_________________________________________
Printed Name of Participant
Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect.

I certify that when this person signs this form, to the best of my knowledge, he or she understands the purpose, procedures, potential benefits, and potential risks of participation.

I also certify that he or she:
- Speaks the language used to explain this research
- Reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her
- Does not have any problems that could make it hard to understand what it means to take part in this research.

__________________________________  _________________________
Signature of Person Obtaining Consent   Date
Most health insurance will not cover services provided by graduate student therapists. The Clinic does not submit claims to insurance companies on your behalf but we can provide you with documentation of services received and payments you made. We do not accept Medicare or DSHS Medical Coupons.

Proof of annual income (previous year's income tax return, pay stub, letter from employer) is required at the time of the intake interview if you wish to be considered for the sliding scale fee.

Note: All confidential information on your document should be redacted (e.g., marked out with heavy black ink) before the therapist views it. This includes social security number, bank account numbers, etc.

The Psychology Clinic will not keep a copy of your document but your therapist will view it only to verify annual income. You have the option of not providing proof of income but will be charged the full fee for services rendered. You will be charged the full fee (full charge rate on the fee schedule) for services rendered.

Consultation with school personnel is billed at the rate of one therapy hour.

Telephone Sessions are charged at the same rate as in-person sessions.

Missed therapy appointments or late cancellations (less than 24-hour notice) are charged at the established sliding fee rate.

Therapy Services Sliding Fee Scale (per session) Telephone Sessions are scheduled for 2 hours and will be billed at two times the established session fee.

Consultation is billed at the rate of one therapy hour.

Missed therapy appointments or late cancellations (less than 24-hour notice) are charged at the same rate as in-person sessions.

Missed therapy appointments or late cancellations (less than 24-hour notice) are charged at the same rate as in-person sessions.

Consultation at the rate of one therapy hour.

Telephone Sessions are charged at the same rate as in-person sessions.

Please discuss this process with your therapist.

Please circle your monthly or annual income and family size (include yourself and all dependents) on the chart below:

<table>
<thead>
<tr>
<th>Monthly Income</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1,416</td>
<td>0 - 16,999</td>
</tr>
<tr>
<td>1,417 - 1,916</td>
<td>17,000 - 22,999</td>
</tr>
<tr>
<td>1,917 - 2,833</td>
<td>23,000 - 33,999</td>
</tr>
<tr>
<td>2,834 - 3,750</td>
<td>34,000 - 44,999</td>
</tr>
<tr>
<td>3,751 - 4,583</td>
<td>45,000 - 54,999</td>
</tr>
<tr>
<td>4,584 - 5,416</td>
<td>55,000 - 64,999</td>
</tr>
<tr>
<td>5,417 - 6,250</td>
<td>65,000 - 74,999</td>
</tr>
<tr>
<td>6,251 - 7,083</td>
<td>75,000 - 84,999</td>
</tr>
<tr>
<td>7,084 +</td>
<td>85,000 +</td>
</tr>
</tbody>
</table>

Parent/Guardian/Authorized Adult: 

Client name: ____________________________  Client #: ________________________

509-335-3387  Fax: 509-335-1030
P.O. Box 644820
Pullman WA 99164-4820

Washington State University
Psychology Clinic

FEE WORKSHEET

Client #:

Relation to Client: _______________________

Most health insurance will not cover services provided by graduate student therapists. The Clinic does not submit claims to insurance companies on

Parent/Guardian/Authorized Adult: 

Client name: ____________________________  Client #: ________________________

509-335-3387  Fax: 509-335-1030
P.O. Box 644820
Pullman WA 99164-4820

Washington State University
Psychology Clinic

FEE WORKSHEET
### Fee Agreement:

#### NOTE: The intake fee is due at the intake session. The remainder of the assessment balance must be paid in full on the first day of testing.

<table>
<thead>
<tr>
<th>Assessment Service</th>
<th>Faculty Services</th>
<th>Neuropsychological Assessment</th>
<th>Diagnostic Clarification</th>
<th>Attention Deficit/Hyperactivity Clarification</th>
<th>Learning Disability/Specific Learning Disability</th>
<th>Emotional and Behavioral Clarification</th>
<th>Intellectual Disability Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$225.00/hour</td>
<td>$300.00</td>
<td>$200.00</td>
<td>$125.00</td>
<td>$75.00/hour</td>
<td>$100.00/hour</td>
<td>$50.00/hour</td>
<td>$25.00/hour</td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td>$200.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$225.00/hour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: The fee schedule does not apply to clients who are referred by agencies with whom the Psychology Clinic has a contract.*

*PROOF OF ANNUAL INCOME (PREVIOUS YEAR'S INCOME TAX RETURN) IS REQUIRED AT THE TIME OF THE INITIAL ASSESSMENT. INCOME MUST BE REPORTED IN THE DOCUMENT.*

*ASSESSMENT SERVICES SLIDING SCALE PER ASSESSMENT BATTERY UNLESS OTHERWISE NOTED (NEUROPSYCHOLOGICAL ASSESSMENT, FACULTY SERVICES, MEMORY NOTEBOOK TRAINING).*