Psychological Services & Training Center
University of Washington, Department of Psychology

CLIENT'S NAME:		DATE OF BIRTH:
STREET ADDRESS:		PREFERRED CONTACT #:
CITY, STATE, ZIP:		EMAIL:
PARTY RESPONSIBLE FOR PAYMENT:	RELATIONSHIP TO PATIENT	HOME PH. #
STREET ADDRESS:		MOBILE PH. #
CITY, STATE, ZIP:		EMAIL:
IN CASE OF EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:	HOME PH. #
STREET ADDRESS:		MOBILE PH. #
CITY, STATE, ZIP:		EMAIL:

University of Washington

Psychological Services and Training Center
Department of Psychology
(206) 543-6511

Informed Consent for Telehealth and In-person Clinical Services: Child and/or Family

Welcome to the Psychological Services and Training Center (the Training Clinic). The Training Clinic is part of the University of Washington's graduate training program in clinical psychology, which is accredited by the American Psychological Association. Most of the therapy is provided by graduate students working toward their doctoral degrees. Student clinicians are supervised by faculty members of the UW Psychology Department and other UW affiliated mental health professionals from the community. Student clinicians are responsible for sharing the names of their supervisors with their clients. After meeting with their supervisors, clinicians should be able to answer any questions you might have about the type of treatment your child or family will be receiving (e.g., behavioral therapy or cognitive behavioral therapy). Whenever possible, our clinicians will draw upon evidence-based principles and practices.

Office Hours: Monday-Thursday 8:30-6:00; Fridays 8:30-5:00 (hours are subject to change). Closed Fridays from mid-June through late September.

Appointments

The initial intake visit will typically last for 1 hour and 20 minutes. Thereafter, regular appointments are usually 50 minutes long. Because your appointment time is held especially for you, **we request 24 hours advance notice to cancel.** No shows and late cancellations are billed at the session rate.

Emergencies

In case of imminent life-threatening emergencies, dial 9-1-1. Call (206) 543-6511 if you wish to reach your clinician or the appropriate back-up person during a crisis. The Clinic staff or the answering service will triage the call and attempt to reach your clinician or the back-up person. If neither is available, the answering service is instructed to patch emergency calls through to the King County Crisis line. Please be sure to tell the Front Desk staff or answering service that it is an emergency; otherwise, they may simply take a message

Fees

- ***Session fees:*** The fee for the initial intake appointment is currently $85. Subsequent routine therapy appointments are based on the Clinic's two-tiered fee scale. Fees are prorated depending upon the length of the appointment (e.g., if you are seen for two hours, you will be charged double your usual fee). Periodically, we may ask you to update your financial information so that your fees may be adjusted accordingly.

- ***Off-site Session fees:*** Occasionally a clinician may need to meet with you outside the Clinic. When that happens, you will be charged the session fee plus mileage fee (as posted on the UW Travel website) plus travel time.

- ***Insurance:*** Health insurance companies typically do not cover psychotherapy provided by graduate students. It is your responsibility to pay for the psychotherapy that you or your child receive. If you choose to submit a claim to your insurer in hopes of reimbursement, we will be happy to provide you with a statement of services.

- ***Copying***: Third parties will be charged a $28.00 processing fee and then $1.24 per page for the first 30 pages and $.94 per page for anything above. Clients and responsible parties of clients will not be charged the processing fee but may pay $0.94 per page. If the provider personally edits confidential information from the record, as required by statute, the provider can charge the usual fee for a basic office visit. These fees are determined by The Washington Administrative Code (WAC 246-08-400) and are in effect May 28, 2020.

Routine Assessment of Therapy Progress

- ***Intake***: The goal of therapy is to help your child or family function better. Building a strong collaborative relationship with your child's or family's clinician is key. Before the intake session, both parent(s) and children (depending on their ages) will be asked to fill out online questionnaires selected specifically for your family. The results of those measures will hopefully help your clinician get to know your family and help you all understand how well you are functioning at the start of therapy and how to plan treatment accordingly. All progress assessment results will be part of the file.

  Throughout treatment: Typically, both parent(s) and children (depending on their ages) will be asked to complete brief online measures designed to help your family's clinician track your child's or family's progress in therapy. You will be able to review the results together with your clinician and then collaboratively discuss any necessary changes in the treatment plan.

- ***Email or Text Invitations and Reminders:*** The assessment measures may be completed online using any web-enabled device (e.g., a computer, tablet or smart phone). You and/or your child (depending on your child's age) will receive email or text notices when your account is ready to be set up and when the online questionnaires are available. If you are uncomfortable receiving these email or text notifications please discuss this with your clinician.

Voluntary Research Participation

We consider assessment of your child or family's progress in therapy to be an important and routine part of providing quality services. We are also interested in sharing what we learn about how to improve training or services with others who share the same mission. Toward that end, you will be asked to allow the use of your child's or family's answers (without any identifying information) in research publications or presentations. All the members of your family who are in treatment and who are age 13 or older will be given an opportunity to read the *Research Informed Consent Form* and have their questions answered before deciding. Every family member 13 or older will be free to decline to participate in the research and if anyone does decline, that will not affect the services that your family receives in any way. Parents or guardians of clients age 12 or younger will decide if their child's data will be used in the research.

Routine Observation and Recording of Therapy Sessions

As part of the Clinic's training function, sessions are routinely recorded and may be observed. Clinicians review the recordings with their supervisors who discuss and give them feedback. Recordings may be used for graduate training purposes during case discussions and case presentations. Since the recordings and observations are essential to the clinicians' training, all clients are asked to give permission. The recordings are destroyed quarterly. However, occasionally recordings may be kept for training purposes only. These recordings are considered property of the University of Washington and may be used only for UW training purposes and will not be shared with clients. Please discuss with your clinician any problems (such as acquaintances among students) that might arise from observations, case discussions and case presentations, etc.

Telehealth

Sessions may be conducted in person (wearing mask) or remotely, using HIPAA-compliant UW Zoom. Even though we use a HIPAA compliant videoconferencing service for telehealth, you will be asked to sign a form that you understand the potential risks to your confidentiality. If you have any questions about using Zoom for telehealth, please discuss with your clinician before the session takes place.

E-mail and Other Forms of Electronic Communication

Many people now use email as a primary form of communication. Email can be a helpful tool in therapy as you can send your clinician updates on your progress or your clinician might send you reminders or encouragement, etc. You have the right under the HIPAA Privacy Rule to request communication by alternate means if reasonable. That said, it is important

to remember that email, cell phones, videoconferencing, etc. cannot be considered completely secure and thus should be used only with an understanding that there is some risk to your confidentiality. For example, although your clinician will make every effort to guard your confidentiality no matter what the means of communication, emails can be hacked; cell phone calls may be similarly compromised, etc. As the client it is your right to decide whether you think that the benefits of communicating over email, cell phone, etc., outweigh the risks. Regardless of the medium, summaries of substantive communications (or the emails, texts, etc.) will be placed in your file. ***Please remember that even if you use email or other means to communicate with your clinician outside of sessions, they are not a good way to reach your clinician in case of emergency.*** See https://www.uwmedicine.org/about/policies-and-notices/email-risk

Clinicians may also electronically communicate information about you with their supervisors or others involved in their training. If they do so, they will guard your or your family's confidentiality by password-protecting all such communications and not using any identifying information.

Clients' Responsibilities

Therapy works best when it is a collaborative effort between clients and clinicians. It is your responsibility to let your clinician know if your goals for therapy have changed or if you are not satisfied with either the process or the results of therapy. While therapy is a collaboration between clinician and client, ultimately you are responsible for choosing a clinician and a treatment modality that best meets your needs. Most of the time, talking to your child's or family's clinician helps improve the situation. Occasionally, however, talking about it with your clinician doesn't help. Under those circumstances, or if you feel that your child's or family's clinician has been unprofessional or unethical, you might want to consider consulting with your clinician's supervisor, the Clinic Director (Corey Fagan, Ph.D.), or the Clinic's intake staff, all of whom will try to help you decide the best course of action.

Clinicians who make sexual overtures toward clients are behaving unethically and their behavior should be reported immediately. You should contact the Washington State Department of Health Psychology Licensing Board at (360) 236-4700 or hsqa.csc@doh.wa.gov

Respect for Others/Respect for Clinic Property

The Clinic is a place where all have the right to feel safe. Toward that end, we expect clients to treat others with courtesy, and to treat Clinic property with care, demonstrating respect for both at all times. And, in keeping with state law, no weapons will be allowed in the Clinic.

Confidentiality:

We keep a record of the services we provide you. You may ask to see, copy or correct that record by contacting your child's or family's clinician or the Clinic Manager and filling out a written request. 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. The content of all sessions will be treated as confidential with the following exceptions:

1) If the clinician has reason to suspect that a child under 18 is or has been abused or has witnessed domestic violence or a developmentally disabled person or an elderly person is being or has been abused, a report must be made to the appropriate authorities.

2) If a client poses a threat to another person, the clinician must take steps to protect the potential victim(s), which might include, but is not limited to, warning the person(s) at risk and reporting the danger to the appropriate authorities.

3) If a client poses a danger to self or is unable to take care of basic needs, the clinician may take appropriate action to protect the client's safety.

4) If a client discloses that he/she is HIV seropositive, does not have a physician monitoring the condition and has unsuspecting IV drug-using or sexual partner(s) we may consult with a public health official.

5) If a client chooses to submit reimbursement claims to an insurance provider, the insurance provider has the right to some limited information about the client's treatment.

6) If a client is involved in a legal battle, a judge may determine that the records must be turned over to the Court.

7) The Uniform Health Act of WA allows some communication among health care providers and between your health care providers and your family members. In most cases, your clinician will not communicate with any of the above without your consent, but you should know that it is allowable.

8) If a client is a health provider licensed by the Washington State Department of Health we are required to report final determinations of unprofessional conduct, actual knowledge of unprofessional conduct and clear and present danger to patient safety due to a mental or physical condition.

9) If a client chooses to use email or other means of electronic communication, the client does so voluntarily and with the understanding that those means may not be 100% secure.

On occasion, your child may share information with their clinician that they do not want shared with their parent or guardian. Clinicians will use their best clinical judgment about what will be in your child's best interest before deciding whether to break your child's confidence. Typical examples might include, but are not limited to, revelations of potentially dangerous behaviors or the intent to engage in potentially dangerous behaviors (e.g., self-starvation, self-harm, substantial drug use, drinking and driving, etc.). Clinicians will attempt to share this information in the most therapeutic way possible, typically by discussing the options with your teenager before talking to you.

Access to Your Patient Records

You have the right to give others access to your child's or family's patient records without a release of information form if you indicate them by name on the lines below. You may revoke this access at any time orally or in writing. Parents of children under 13 may sign for their children below. Minors ages 13-17 should sign for themselves.

I wish to give the following people access to my protected health information, payment and appointment information, and other information pertaining to my services if applicable:

_____ _____

_____ _____

Follow-up/Emergency Contact

This is a person who would know how to contact you if you have moved; or in case of emergency.

Name/Relationship: _____

Phone: _____Email: _____

Address: _____

Acknowledging Receipt of the Notice of Privacy Practices

The UW Psychological Services and Training Center and Certain Other Providers Joint Notice of Privacy Practices (Joint Notice of Privacy Practices) describes how medical information about you may be used and disclosed and how you can get access to this information. We are required by law to protect the privacy of your information, provide the *Joint Notice of Privacy Practices*, and follow the information practices that are described in this notice. If you have any

questions or complaints, please contact the Clinic Manager at 206-543-6511. Note: we may change our policies at any time, and you will be notified of any significant policy change.

Statement of Informed Consent for Treatment

I have read and fully understand the preceding description and conditions of the Psychological Services and Training Center's treatment program. I agree to allow observation and audio or videotaping and to permit my clinician to discuss my treatment for purposes of training and supervision. I understand that filling out measures of my child's or family's treatment progress is considered a routine and required part of services and that I and/or my child will receive email or text notices about these measures. The limits of confidentiality have been explained to me and I also understand that I may withdraw from therapy at any time without penalty.

I further understand that my family and I are receiving psychological services through the Psychological Services and Training Center and that in order for these services to be helpful it is important that the records of any counseling sessions not be used in court. Therefore, I agree that all records of any counseling sessions involving me or my children, the biological or custodial parent(s) of my children the guardian(s) of my children or anyone else seen in conjunction with my family here at the Psychological Services and Training Center will be kept confidential and not be used in any current or future legal proceedings. I understand that this agreement will hold even if any attorney requests records of the psychological services received by me or my family from the Psychological Services and Training Center.

Signature of teenage clients, ages 13-17

Print Name(s) Here and Sign Below: _____

Signature: (1)_____ Date: _____

Signature: (2)_____ Date:_____

AND

Signature of Parent(s) or Guardian(s) if client is a minor, under 18 years of age

Print full name and relationship to minor client.

Name/Relationship: _____

Signature: _____ Date: _____

Name/Relationship: _____

Signature: _____ Date: _____

Signature of clinician: _____ Date: _____

cc: client; client file

University of Washington
PSYCHOLOGICAL SERVICES AND TRAINING CENTER
Box 351635 - Seattle, Washington 98195
206-543-6511

BILLING AND COLLECTIONS POLICY
Psychology Training Clinic
(Graduate Student Therapists)

The Psychology Training Clinic is a non-profit training facility that charges fees to support its operations.

Payment of Fees:

- We accept credit, debit and Health Savings cards and checks. Checks should be made payable to the **University of Washington**.

- Your payment will be processed by Student Fiscal Services (SFS) at UW. SFS processes checks electronically using the information on the check to create an electronic funds transfer. Each time you pay with a check, you authorize a one-time transfer where funds will be electronically withdrawn from your bank account. You will not receive your canceled check as SFS is required to destroy the check after it has been processed. Please contact SFS at (206) 543.4694 or email at sfshelp@u.washington.edu if you have any questions.

- If your check is returned by the bank due to insufficient funds, you will be charged a $25 NSF fee, and we may require that future payments be made by cash or credit card.

- Payment responsibilities for Psychology Training Clinic services are as follows:

  PSYCHOTHERAPY SERVICES
  Payment for each individual therapy session is due when you check in for your appointment.

  ASSESSMENT/EVALUATION SERVICES
  (Substance use evaluations, IQ testing, focused ADHD evaluations)
  Payment in full is due on the first day of service.

  GROUP THERAPY & SKILLS GROUPS
  Payment for group participation is based on group duration (ongoing or time-limited), length of group sessions, and whether or not a workbook is required. Payment responsibilities are explained at the time of group enrollment. *No refunds will be given for missed group sessions.*

- A fee will be charged for psychotherapy or evaluation sessions if they are cancelled with less than 24 hours notice (with the exception of group therapy and skills groups).

- If you have any questions or concerns about your account, or anticipate difficulty in making payments on time, please contact the Clinic Manager.

Client/Responsible Party Statement:

I understand that I am responsible for payment for all services received. I have read and understand the contents of this Billing and Collections Policy.

_____	_____
Client Name (print)	Responsible Party Name if different than Client (print)
_____	_____
Signature (Client or Responsible Party)	Date

Revised 08.16.2022

Joint Notice of Privacy Practices of
UW Psychological Services & Training Center Providers

September 12, 2013

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.

Overview

This Notice provides information regarding use and disclosure of protected health information (PHI) by UW Psychological Services and Training Center, The LEARN Clinic, the FAP Clinic, The Parent Child Clinic, the CALM Clinic, the Marsha M Linehan DBT Clinic and the Faculty Clinic– collectively, the UW Psychological Services & Training Center Providers.

This Notice applies when services are provided within UW Psychological Services & Training Center, and/or when the Providers are acting as part of one or more of the joint arrangements described below. This Notice also:

- Describes your rights and our obligations for using your health information.
- Informs you about laws that provide special protections.
- Explains how your PHI is used and how, under certain circumstances, it may be disclosed.
- Tells you how changes to this Notice will be made available to you.

The Providers

UW Psychological Services and Training Center. UW Psychological Services and Training Center is composed of multiple affiliated entities that work together to provide health care services and to perform payment and health care operations. UW Psychological Services and Training Center entities will share information, as necessary, to provide health care services (including mental health), and to perform payment and health care operations. UW Psychological Services and Training Center includes the following entities or operations:

- UW Psychological Services and Training Center graduate student training clinic
- The LEARN Clinic, which provides testing services for learning disabilities and other disorders
- The FAP Clinic graduate student training clinic
- The Parent Child Clinic, which provides behavioral parent training
- The CALM Clinic, which provides assessment and treatment services for anxiety, traumatic stress, and obsessive-compulsive related disorders
- The Marsha M Linehan DBT Clinic provides services for problems associated with suicide, self-harm and severe emotional dysregulation
- Faculty Clinic, which is composed of Psychology Department faculty who provide clinical services to clients

Protected Health Information

This Notice applies to protected health information (PHI) created or received by the Providers in this Notice at UW Psychological Services and Training Center —that identifies you; relates to your past, present or future physical or mental condition; relates to the care provided; or relates to the past, present or future payment for your healthcare. For example, PHI includes your symptoms, test results, diagnoses, treatment, health information and other providers, and billing and payment information relating to these services. This information often contained in your medical record, among other purposes, serves as:

- A means of communication among the many health professionals who contribute to your care.
- The legal record describing the care you received.
- A means by which you or a third-party payer (such as healthcare insurance) can verify that services billed were provided.
- A tool to educate health professionals.

- A source of data for medical research.
- A source of information for public health officials.
- A source of information for facility planning.
- A tool we use to improve the care we give and the outcomes we achieve.

Understanding what is in your record and how your health information is used and disclosed helps you to:

- Ensure accuracy in the record.
- Better understand who, what, when, where, and why others may access your health information.
- Make a more informed decision when authorizing disclosures to others.

Use and Disclosure of Your Protected Health Information without Your Authorization

We may use and disclose PHI without your written authorization for the following reasons:

To Provide Treatment. For example:

- Your treatment provider uses your PHI to determine whether specific diagnostic tests, therapies, and medicines should be ordered.
- Clinical supervisors, clinical graduate students, or other clinical personnel (e.g. the Clinic Director) may need to know and/or discuss your problems to carry out treatment and to understand how to evaluate your response to treatment.
- We may disclose your PHI to another one of your treatment providers in the community, unless the provider is not currently providing treatment to you and you direct us in writing not to make the disclosure. However, under most non-emergency situations, we will ask for your verbal or written authorization before doing so.

For Payment Purposes. For example:

- We may use PHI to prepare claims for payment of services you have received.
- If you have health insurance and we bill your insurance directly, we will include information that identifies you, as well as your diagnosis, the procedures performed, and supplies used so that we can be paid for the treatment provided. However, we will not disclose your PHI to a third-party payor without your authorization except when required by law.

For Healthcare Operations. We may use and disclose your PHI to support daily activities related to healthcare, for example, to monitor and improve our health services or for authorized staff to perform administrative activities.

To Train Staff and Students. For example, when our clinical supervisors review PHI with graduate student staff.

To Conduct Research An Institutional Review Board (IRB) will review each request to use or disclose your PHI to protect the rights, safety, and welfare of research subjects. In some cases, your PHI might be used or disclosed for research without your consent. For example, a researcher might include your information in a research database that removes most or all of your PHI.. In these cases, the IRB will determine if using your information without your authorization is justified, and makes sure that steps are taken to limit its use. In all other cases, we must obtain your authorization to use or disclose your information for a research project. We may share information about you used for research with researchers at other institutions.

To Contact You for Information. Your PHI may be used to call you or send you a letter to remind you about appointments, provide diagnostic results, inform you about treatment options, advise you about other health-related benefits and services, or about balances on your account.

To Conduct Fundraising. The Providers may use basic demographic information limited to your name, date of birth, address, phone number, health insurance status, and the dates you received services, department of service information, treating physician information, outcome information, to contact you for fundraising activities. The Providers do not access your diagnosis or treatment information for fundraising activities. We will not prohibit or condition treatment or payment on whether you choose to receive fundraising communications. We raise funds to expand and support healthcare services, educational programs, and research activities related to curing disease. We will not sell, trade, or loan your information to any third parties, but the Providers may share it with

third parties working directly for one of the Providers. These third parties must agree to protect the confidentiality of your information. If you do not wish to be contacted as part of our fundraising efforts, please notify us in writing at:

UW Psychological Services & Training Center
Attention: Clinic Manager
Box 351635
Seattle, WA 98195-1635

Joint Activities. Your health information may be used and shared by the Providers to further their joint activities and with other individuals or organizations that engage in joint treatment, payment or healthcare operational activities with the Providers. Health information is shared when necessary to provide clinical care services, secure payment for clinical care services, and perform other joint healthcare operations such as peer review and quality improvement activities, accreditation related activities, and evaluation of trainees.

Business Associates. Your health information may be used by the Providers and disclosed to individuals or organizations that assist the Providers or to comply with their legal obligations as described in this Notice. For example, we may disclose information to consultants or attorneys who assist us in our business activities. These business associates are required to protect the confidentiality of your information with administrative, technical and physical safeguards.

Other Uses and Disclosures. We also use and disclose your information to enhance healthcare services, protect patient safety, safeguard public health, ensure that our facilities and staff comply with government and accreditation standards, and when otherwise allowed by law. However, we will not do this without talking with you. For example, we provide or disclose information:

- To government oversight agencies with data for health oversight activities such as auditing or licensure.
- To your employer, findings relating to the medical surveillance of the workplace or evaluation of work-related illnesses or injuries.
- To workers' compensation agencies and self-insured employers for work-related illness or injuries.
- To appropriate government agencies when we suspect abuse or neglect.
- To appropriate agencies or persons when we believe it necessary to avoid a serious threat to health or safety or to prevent serious harm.
- To law enforcement when required or allowed by law.
- For court order or lawful subpoena.
- To government officials when required for specifically identified functions such as national security.
- When otherwise required by law, such as to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with our obligations to protect the privacy of your health information.
- If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Use and Disclosure When You Have the Opportunity to Object

Disclosure to and Notification of Family, Friends, or Others. Unless you object, your healthcare provider will use his or her professional judgment to provide relevant protected health information to your family member, friend, or another person. This person would be someone that you indicate has an active interest in your care or the payment for your healthcare or who may need to notify others about your location, general condition, or death.

Disclosure for Disaster Relief Purposes. We may disclose your location and general condition to a public or private entity (such as FEMA or the Red Cross) authorized by its charter or by law to assist in disaster relief efforts.

Use and Disclosure Requiring Your Authorization

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. UW Psychological Services and Training Center requires your written authorization for most uses and disclosures of psychotherapy notes, for marketing (other than a face-to-face communication between you and a UW Psychological Services and Training Center workforce member or a promotional gift of nominal value); or before selling your protected health information. If you provide us with written authorization, you may revoke it at any time unless disclosure is required for us to obtain payment for services already provided, we have otherwise relied on the authorization, or the law prohibits revocation. Also, in some situations, federal and state laws may provide special protections for certain kinds of protected health information, such as drug or alcohol treatment records. When required by those laws, we may contact you to receive written authorization to use or disclose that information.

Additional Protection of Your Patient Health Information

Special state and federal laws apply to certain classes of patient health information. For example, additional protections may apply to information about sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records, and HIV/AIDS information. When required by law, we will obtain your authorization before releasing this type of information.

Your Individual Rights about Patient Health Information

You have rights related to the use and disclosure of your protected health information. To contact the Providers to exercise your rights, you may contact:

UW Psychological Services & Training Center
Attention: Clinic Manager
Box 351635
Seattle, WA 98195-1635
(206) 543-6511

Your specific rights are listed below:

- **The right to request restricted use:** You may request that certain individuals or entities not be given access to your PHI. To make this request, contact the Clinic Manager for a copy of the *Request to Consider Additional Privacy Protection for Protected Health Information*. You may request in writing that we not use or disclose your information for treatment, payment, and/or operational activities except when authorized by you, when required by law, or in emergency circumstances. We are not legally required to agree to your request. Make your request to UW Psychological Services and Training Center; we will provide you with written notice of our decision about your request.

- **The right to request nondisclosure to health plans items or services that are self-paid:** You have the right to request in writing that healthcare items or services for which you self-pay for in full in advance of your visit not be disclosed to your health plan.

- **The right to receive confidential communications:** You have the right to request that we communicate with you about medical matters in a particular way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the address above. We will grant all reasonable requests. Your request must specify how or where you wish to be contacted.

- **The right to inspect and receive copies:** In most cases, you have the right to inspect and receive a copy of certain healthcare information including certain medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- **The right to request an amendment to your record:** If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that we make a correction or add information. In your request for the amendment, you must give a reason for the amendment. We are not required to agree to the amendment of your record, but a copy of your request will be added to your record.

- **The right to know about disclosures:** You have the right to receive a list of instances when we have disclosed your health information. Certain instances will not appear on the list, such as disclosures for treatment, payment, or healthcare operations or when you have authorized the use or disclosure. Your first accounting of disclosures in a calendar year is free of charge. Any additional request within the same calendar year requires a processing fee.

- **The right to make complaints:** If you are concerned that we have violated your privacy, or you disagree with a decision we made about access to your records, you may file a complaint with UW Psychological Services and Training Center, the entity that provided services to you. The Providers will not retaliate against anyone for filing a complaint.

If you believe that your privacy rights have been violated, you may also contact the U.S. Department of Health and Human Services • Office for Civil Rights:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue – Mail Stop RX-11
Seattle, WA 98121-1831
206-615-2290; 206-615-2296 (TTY)
206-615-2297 (fax)
Toll free: 1-800-362-1710; 1-800-537-7697 (TTY)

Our Legal Duties

We are required by law to; protect the privacy of your information, notify affected individuals following a compromise of unsecured protected health information, provide this Notice about our privacy practices, and follow the privacy practices that are described in this Notice.

Privacy Notice Changes

We reserve the right to change the privacy practices described in this Notice. We reserve the right to make the revised or changed Notice effective for protected health information we already have as well as any information we may receive in the future. We will post a copy of the current Notice in a conspicuous place in our reception area. In addition, each time you check-in for an appointment you may request a copy of the current Notice from your care provider. An electronic version of the notice is posted at **http://www.psych.uw.edu/psych.php?p=379**

Notice of Privacy Practices Acknowledgment

The Notice of Privacy Practices of UW Psychological Services and Training Center Providers handout describes how medical information about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns or complaints.

We have a responsibility to protect the privacy of your information, provide a Notice of Privacy Practices and follow the information practices that are described in this Notice. If you have any questions, please contact the Clinic Manager at (206) 543-6511.

Please do not write comments on this form; refer to "Your Individual Rights about Patient Health Information" in the Notice of Privacy Practices.

We may change this policy at any time. Any significant policy change will be posted. You may request a copy of this notice from the Clinic Manager or by visiting our website at http://www.psych.uw.edu/psych.php?p=379

Patient Name:	Date of Birth:

By signing below, I agree that I have received the Notice of Privacy Practices of UW Psychological Services and Training Center Providers.

Signature (Patient or Person Authorized to give Authorization	Date
If other than patient, print name of person signing	
If signed by person other than patient, check relationship to patient: Parent(s) ____ Guardian____ Durable Power of Attorney for Health Care ____ Spouse/Registered Domestic Partner ____ Adult Child(ren) ____ Adult Brother(s)/Sister(s) ____	
FOR MINOR PATIENTS Parents ____ Guardian/Legal Custodian ____ Holder of signed authorization from parent(s) ____ Court-authorized person for child in out-of-home placement ____ Adult representing self to be a relative responsible for the minor's health ____	

UNIVERSITY of WASHINGTON
HUMAN SUBJECTS DIVISION

HIPAA Authorization

[redacted]

For the Use of Patient Health Information for Research

Research Title:	Psychological Services and Training Center Research Database
Lead researcher:	Corey Fagan, Ph.D.
Institution of lead researcher:	University of Washington

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A. Purpose of this form

The purpose of this form is to give your permission to the research team to obtain and use your patient information. Your patient information will be used to do the research named above.

This document is also used for parents to provide permission to the research team to obtain the patient information of their minor children, and for legally-authorized representatives of subjects (such as an appropriate family member) to provide permission to the research team to obtain patient information of individuals who are not capable themselves of providing permission. In such cases, the terms "you" and "your patient information" refer to the subject rather than the person providing permission.

A minor's signature is required to release the following information about the minor: 1. Age 14 and older – information relating to reproductive care, including but not limited, to birth control and pregnancy-related services and sexually-transmitted diseases, including HIV/AIDS and 2. Age 13 and older – substance abuse diagnosis or treatment, and mental health information.

State and federal privacy laws protect your patient information. These laws say that, in most cases, your health care provider can release your identifiable patient information to the research team only if you give permission by signing this form.

You do not have to sign this permission form. If you do not, you will not be allowed to join the research study. Your decision to not sign this permission will not affect any other treatment, health care, enrollment in health plans or eligibility for benefits.

B. The patient information that will be obtained and used

"Patient information" means the health information in your medical or other healthcare records. It also includes information in your records that can identify you. For example, it can include your name, address, phone number, birthdate, and medical record number.

1. Location of patient information

By signing this form you are giving permission to the following organization(s) to disclose your patient information for this research

- UW Psychology Clinics in the School of Arts and Sciences (UW Psychological Services & Training Center; The LEARN Clinic; the Faculty Clinic)

2. Patient information that will be released for research use

This permission is for the health care provided to you during the following time period: from your first session (intake) at the Psychological Services and Treatment Center to your last session (termination) at the Psychological Services and Treatment Center.

The specific information that will be released and used for this research is described below:

- Hospital discharge summary
- Medical history / treatment
- Consultation
- Psychological testing
- All records containing psychiatric, mental status, and psychological treatment information.

C. How your patient information will be used

The researcher will use your patient information only in the ways that are described in the research consent Form that you sign and as described here.

The research consent form describes who will have access to your information. It also describes how your information will be protected. You can ask questions about what the research team will do with your information and how they will protect it.

If the results of this study are made public, information that identifies you will not be used.
The researcher will use your patient information only in the ways that are described in the research consent form that you sign and as described in this HIPAA Authorization.

The privacy laws do not always require the receiver of your information to keep your information confidential. After your information has been given to others, there is a risk that it could be shared without your permission.

You have the right to obtain your patient information in your healthcare record. The study procedures do not include a plan to share your research results, though you may be able to request them through the Washington State Public Records request system after the study is done.

D. Expiration

This permission for the researchers to obtain your patient information will expire when the purposes of the study have been met. This will happen no later than 10 years after the conclusion of your treatment at the Psychological Services and Treatment Center.

E. Canceling your permission

You may change your mind at any time. To take back your permission, you must send your **written** request to: Dr. Corey Fagan, coreyf@uw.edu

If you take back your permission, the research team may still keep and use any patient information about you that they already have. But they can't obtain more health information about you for this research unless it is required by a federal agency that is monitoring the research.

If you take back your permission, you will need to leave the research study. Changing your mind will not affect any other treatment, payment, health care, enrollment in health plans or eligibility for benefits.

F. Giving permission

I have read this HIPAA Authorization form describing how my patient information will be used. I have had a chance to ask questions about the use of my patient information and I have received answers to my questions. I agree to the use of my patient information for this research.

To release the specific information listed below, you need to also write your initials next to the type of information. This is your specific permission for release of this information, which is required by Federal and

state laws. The federal rules bar any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ Behavioral or mental health/illness, including psychotherapy notes
_____ Drug or alcohol abuse, diagnosis, or treatment

Printed Name of Research Subject | Birthdate

Signature of Research Subject | Date of signature

Printed Name of Person Authorized to Give Permission

Signature of Person Authorized to Give Permission | Date of signature

Relationship to Subject and Description of Authority
(Examples: parent of a young child; sister of an individual who is in a coma; researcher who signs for a subject who is unable to physically sign the authorization but was observed by the researcher to read and otherwise agree to the authorization.)

You will receive a copy of this signed form. Please keep it with your personal records.

Approved
3/15/2021
UW IRB

UNIVERSITY OF WASHINGTON

Psychological Services and Training Center
Department of Psychology

PSTC Research Database
Research Consent/Assent Form: Adult, Parent/Guardian, Teen 13-17

Researcher: Corey Fagan, Ph.D., Director, Psychological Services and Training Center, (206) 543-6511.

RESEARCHER'S STATEMENT

We are asking you to participate in a research project. The purpose of this consent form is to give you the information you will need to help you decide whether to participate. Please read this form carefully. You may ask questions about what we will ask you to do, the risks, the benefits, your rights as a volunteer, or anything else about the research project or this form that is not clear. When we have answered all of your questions, you can decide if you want to participate. This process is called "informed consent." We will give you a copy of this form for your records.

This form is addressed to "you," which can refer to adults consenting for themselves and to parents giving permission for their child's participation. This form is also addressed to teens who are 13 or older, who can give assent on this form along with their parent's permission. Children aged 7 to 12 will have a separate assent procedure. Children younger than 7 will not be asked for separate assent.

PURPOSE of the STUDY

The purpose of this project is to create a research database of information, collected as part of regular clinical care at the Psychological Services and Training Center (PSTC), that can later be analyzed to examine symptoms, life functioning, assessment and treatment processes, with the ultimate hope of improving behavioral health diagnosis, assessment or treatment. You have been asked to take part because you are receiving behavioral health services at the PSTC.

PROCEDURES

We are asking your permission to put some of the clinical data from your care at the PSTC in the database. Your name and other identifying information will not be directly connected to your information in the research database. Instead, we will give your data a Research ID number. The list linking your Research ID with your identifiable information (specifically your PSTC ID) will be kept separate from all other study data, and will be stored on a password protected computer in a locked room.

Dr. Fagan and other members of the research team will protect the data from being revealed in ways that could identify you. Your information might be used for future studies. We may remove anything that might identify you from the information. If we do so, that information may then be used for future research studies or given to other researchers without getting additional permission from you. It is also possible that in the future we may want to use or share study information that might identify you. If we do, a review board will decide whether or not we need to get additional permission from you. If researchers outside the research team wish to use the database, they will be given totally de-identified data. That is, they will not have access to the link between your name and the information so would have no way to identify you.

Clinical data to be included in the database will include your demographic and patient-reported outcome (PRO) data as well as clinical information from the intake and closing summary made by your therapist: diagnosis, treatment focus, course of treatment, dates of services, and type of treatment. If you choose to participate, we will also need your initials and signature on an additional HIPAA form that gives researchers permission to access clinical data.

The data from this database will be used only for scientific or educational purposes. It may be presented at scientific meetings and/or published in professional journals or books, or used for purposes that the University of Washington's Department of Psychology considers proper in the interest of education, research, or scholarship.

Approved
3/15/2021
UW IRB

RISKS, STRESS, or DISCOMFORT

Participation in this project may involve some added risks or discomforts above and beyond what you might experience as a recipient of behavioral health services at the PSTC. There is a small risk of loss of confidentiality that is present with even the most secure technologies. We have taken steps to reduce this risk as described above.

BENEFITS of the STUDY

We do not expect you will directly benefit from including your data in the research database. Research that results from this database could potentially answer import questions regarding behavioral health treatment process and outcome, which in turn could help alleviate suffering for the 1 in 4 Americans who struggle with mental or behavioral health issues over the course of their lifetimes.

OTHER INFORMATION

If this project is reviewed by University or government officials, and if your records are examined, the reviewers will protect your privacy. The records will not be used to put you at legal risk of harm.

There is no payment for allowing your information to be used for research presentations and publications. We may withdraw your form the research database without your consent if we believe it is in your best interest.

Participation in this project is voluntary. You may choose not to participate, and you may withdraw your consent at any time without penalty. Choosing to participate or not participate will not affect your eligibility for services or your care at the PSTC in any way.

_____

Printed name of study staff obtaining consent

_____ _____

Signature **Date**

Subject's Statement—(Adult Subject, Parent/Guardian of minor, teen 13-17)

This research project has been explained to me. I have had a chance to ask questions. I give permission to the researchers to use de-identified information from my clinical record and outcomes data as described in this consent form. If I have questions later about the project or feel I have been harmed by the study, I can ask the researcher listed above. If I have questions about my rights as a research subject, I can call the Human Subjects Division at (206) 543-0098. I will receive a copy of this consent form.

When subject is an adult or teen, 13-17:

_____

Printed name of subject

_____ _____

Signature of subject Date

When subject is a minor (under the age of 18):

_____

Printed name of parent/guardian

_____ _____

Signature of parent/guardian Date

University of Washington
Psychological Services and Training Center
Department of Psychology
(206) 543-6511

Consent for Participation in Telehealth Sessions—Child/Family

1. I consent to video or audio telehealth session(s) for my child or family with the clinician via HIPAA-compliant UW Zoom.

2. I understand that for training purposes the telehealth sessions will be recorded and that the recordings will be stored in a HIPAA-compliant location. The recordings can only be accessed by authorized personnel (e.g., UW Department of Psychology supervisors), using secure passwords. The recordings will be deleted in keeping with standard Clinic procedures.

3. I agree to inform my clinician of my child or family's location at the beginning of each session, so that the clinician knows how best to intervene in case of emergency.

4. I understand that these sessions are billed at the same rate as in-office sessions and that session fees will be prorated if the telehealth session is longer or shorter than 50 minutes.

5. I understand that there are potential risks to the technology, including interruptions, unauthorized access and technical difficulties. Though all reasonable precautions will be taken to protect my child or family's private health information (PHI), there is still the possibility that the information may be exposed during telehealth sessions.

6. I understand a telehealth session should be treated like an in-office session (e.g., held in a private location with minimal distractions and starting and ending on time). Ideally, both parties will use headphones to protect privacy.

7. I understand that my clinician(s) or I can discontinue the telehealth session if it is felt that telehealth is not appropriate for the situation (e.g., in case of emergency or in case of inadequate internet connectivity).

8. If the technology fails (e.g., due to power outages or technical difficulties), I understand that the clinician will make a good faith effort to work with me to ensure continuity of care until the technology can be re-instated.

9. My questions regarding telehealth have been answered and I consent for my child or family to participate in telehealth sessions under the terms described in this document. If I am unable to sign this document electronically, I hereby give my verbal consent on behalf of my child or family and agree to sign this consent the next time I am able to see my clinician in person.

Signature of Parent(s) or Guardian(s) if client is a minor, under 18 years of age.

Print full name and relationship to minor client.

_____ _____

Name/Relationship Signature Date

_____ _____

Name/Relationship Signature Date

_____

Emergency Contact-Name/Phone

_____ _____

Signature of Clinician Date