Parent and Child Clinic

University of Washington, Department of Psychology

3917 University Way NE #140
Seattle, WA 98105

Voice: (206) 543-6511
Fax: (206) 616-8367

Please use BLACK or BLUE ink when filing out this

NAME of PERSON COMPLETEING THIS FORM	HOME PH. #	WORK PH. #
I AM COMPLETEING THIS FOR MYSELF	**(PLEASE CIRCLE)** SOMEONE ELSE	IF SOMEONE ELSE, WHAT IS YOUR RELATIONSHIP TO THE CLIENT?
CLIENT'S NAME:	DATE OF BIRTH:	HOME PH. #
ADDRESS:		MOBILE PH. #
		EMAIL:
IN CASE OF EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT	HOME PH. #
ADDRESS:		MOBILE PH. #
		EMAIL:
PARTY RESPONSIBLE FOR PAYMENT:	RELATIONSHIP TO PATIENT:	HOME PH. #
ADDRESS		MOBILE PH. #
		EMAIL:

University of Washington

Parent and Child Clinic
Department of Psychology
(206) 543-6511

Informed Consent for Clinical Services

Welcome to the Parent and Child Clinic. The Parent and Child 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. All student clinicians are closely supervised by the Director of the Parent and Child Clinic, who is a licensed psychologist. 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 you 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: Wednesdays, 8:30 a.m. – 7:00 p.m.

Appointments

The initial intake visit will typically last 2 hours. Thereafter, regular appointments are usually 60 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 Front Desk 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 based on the provider being seen. The charge to see Dr. Kirkpatrick is $280 for the intake appointment and the charge to see a student clinician is $100 for the intake appointment. For subsequent sessions the fee for Dr. Kirkpatrick is $220 an hour and the student clinician charge is 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.

***Insurance*: As a client of the Parent and Child Clinic, you are solely responsible for payment in full of your bill.** The Parent and Child Clinic is not a contracted provider for any insurance companies and will not directly bill insurance companies or accept direct payment from them. You may submit claims to your insurance company for reimbursement of your payment for the services provided by the Parent and Child Clinic. However, you must pay your bill in full on time even if you plan to request insurance company reimbursement. The information usually required to make a claim is provided on the billing invoice that you will receive after each appointment. If additional information is required, please let us know.

Health insurance companies typically do not cover psychotherapy provided by graduate students. It is your responsibility to pay for the psychotherapy that you, your child or family receives. 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.

We do not accept Medicaid or Medicare, and persons with this coverage cannot be seen at The Parent and Child Clinic. As a Parent and Child Clinic client, you are required to sign our Billing and Collections Policy form, which was provided, along with this form, in the intake packet.

Copying: Third parties will be charged a $26.00 processing fee and then $1.17 per page for the first 30 pages and $.88 per page for anything above. Clients and responsible parties of clients will not be charged the processing fee, but will pay $0.75 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 effective September 7, 2017.

Routine Assessment of Therapy Progress

- ***Intake***: The goal of therapy is to help you, your child or family function better. Building a strong collaborative relationship with your, 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 some 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.

  Weekly and Monthly: Typically you or both parent(s) and children (depending on their ages) will be asked to fill out a handful of brief online measures designed to help your, your child or family's clinician track your, 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.

- ***Therapy Completion***: At the end of treatment, we will ask you, both parent(s) and children (depending on their ages) to fill out a set of outcome measures and a questionnaire about your, your child or family's satisfaction with treatment. We may also contact you 3 months after therapy ends to see whether you have been able to maintain improvements made during therapy.

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

Voluntary Research Participation

We consider assessment of your, 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. At some point you may be asked to allow the use of your, your child's or family's answers (without any identifying information) in research publications or presentations. If you are asked to allow the use of your data as part of research, 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 you, your child or 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 some may be observed through a one-way mirror. 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 after 60 days. 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.

Videoconferencing of Therapy Sessions

From time to time a session may be conducted as a videoconference session. Most videoconferencing services are not HIPAA compliant. However, we use HIPAA-compliant UW Zoom. Even though we use a HIPAA compliant videoconferencing service you will be asked to sign a form that you understand the potential risks to your confidentiality. If you have any questions about using videoconferencing 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 into; 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 http://uwmedicine.washington.edu/Global/Compliance/Pages/Risks-of-Using-Email.aspx

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, your child's or family's 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, 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, 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 N. Fagan, Ph.D.) the Parent Child Clinic Director (Neil Kirkpatrick, 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 (800) 525-0127 or www.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 for 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 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.

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. You may request a copy of the complete version at any time from our reception desk or from the Clinic Manager; or visit our website at http://web.psych.washington.edu/clinic/

Statement of Informed Consent for Treatment

I have read and fully understand the preceding description and conditions of the Parent Child Clinic's services. I agree to allow observation and audio or videotaping and to permit my clinician to discuss my treatment for purposes of training and supervision. 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 Parent Child Clinic 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 Parent Child Clinic 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 Parent Child Clinic.

Print Name(s) Here and Sign Below: _____

Signature: (1)_____ Date: _____

Signature: (2)_____ Date:_____

OR

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
Parent and Child Clinic

Payment of fees:

- We accept credit cards, checks and cash payments (limited to ability to provide change). Checks should be made payable to the **University of Washington**.
- Your check payment will be processed by Student Fiscal Services (SFS) at University of Washington. SFS processes checks electronically using the information on the check to create an electronic funds transfer. Each time you pay with 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. For more information or to stop the conversion of your check, please contact SFS at (206) 543.4694 or email at sfhelp@uw.edu.
- 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
- We do not bill insurance companies for Parent and Child Clinic sessions. We will provide the appropriate insurance codes for you to directly contact your insurance company to ask about reimbursement. However you are responsible for paying your balance in full and on time.
- Health insurance companies typically do not cover psychotherapy provided by graduate students. It is your responsibility to pay for the psychotherapy that you 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.
- A fee will be charged for psychotherapy sessions if they are canceled with less than 24 hour notice.
- If you have any questions or concerns about your account, or anticipate difficulty in making payments on time, please contact the Clinic Manager, 206-543-6511.

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

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

Consent for Participation in Telehealth Sessions

1. I choose to engage in a video or audio telehealth session with my clinician via HIPAA-compliant UW Zoom.

2. I understand that for training purposes my telehealth sessions will be recorded and that the recordings will be password protected and 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 location at the beginning of each session, so that my clinician knows how best to intervene in case of emergency.

4. I understand I will be paying for these sessions at the same rate that I pay for in-office sessions and that session fees will be prorated if my 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 private health information (PHI), there is still the possibility that my 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 my 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 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 and agree to sign this consent the next time I am able to see my clinician in person.

_____ _____

Client Name Signature Date

_____ _____

Address Phone

_____

Emergency Contact

_____ _____

Parent/Guardian/POA Name Signature Date