WSU PSYCHOLOGY CLINIC
APPLICATION FOR SERVICES & BACKGROUND QUESTIONS
(FOR CHILD/ADOLESCENT CASES)

Today's Date_____ Client ID #_____

Client (Child) Name: _____
(First, Middle, Last)

Child's Birth date: _____ Child's Age: _____ Child's Gender: _____

Name of Parent/Guardian/Authorized Representative for a child or adolescent:

_____

Relationship to child (circle one): Biological Mother Biological Father Stepmother Stepfather

Adoptive Mother Adoptive Father Grandparent Other: _____

Address: _____
(Street, City, State, Zip)

Phones: Cell: _____ Work: _____ Home: _____

Where would you prefer we leave a message (check all that apply)? ____ Cell ____Work _____Home

In case of emergency, notify: _____ Phone: _____

Relationship to child: _____

Child's Race/Ethnicity:

_____ African American/Black/African
_____ American Indian/Alaskan Native
_____ Asian American/Asian
_____ East Indian
_____ Hispanic/Latino/Latina
_____ Arab American/Arab/Persian
_____ Native Hawaiian/Pacific Islander
_____ Caucasian/White/European American
_____ Multi-Racial: _____
_____ Other: _____

Where was your child born? _____

Who referred you/how did you hear about us? _____

Reason for seeking services: _____

If you are seeking an assessment, is there a deadline by which this testing needs to be completed?
Yes No If yes, by when? _____

FAMILY INFORMATION

Parent's Relationship Status:

____Single ____Separated ____Civil Union, domestic partnership or equivalent
____Married ____Widowed ____ Engaged ____Divorced

If separated, divorced, or widowed, age of child when it occurred? _____

If separated or divorced, who has legal custody? _____

Parent's occupation: _____ Parent's occupation: _____

Parent's highest level of education: _____ Parent's highest level of education: _____

Parent's Race/ethnicity: (put P1 and P2)

_____ African American/Black/African
_____ American Indian/Alaskan Native
_____ Asian American/Asian
_____ East Indian
_____ Hispanic/Latino/Latina
_____ Arab American/Arab/Persian
_____ Native Hawaiian/Pacific Islander
_____ Caucasian/White/European American
_____ Multi-Racial: _____
_____ Other: _____

Primary language spoken in the home: _____

People living in the household:

Name	Age	Relationship to Child

What is your family's religious affiliation(s)? (check all that apply)

_____ Agnostic
_____ Atheist
_____ Buddhist
_____ Christian: _____
_____ Hindu
_____ Jewish
_____ Muslim
_____ Unitarian Universalist
_____ Other: _____

How important is religion to your family?

Not important				Very Important
1○	2○	3○	4○	5○

ACADEMIC INFORMATION

Name of School: _____

Grade: _____ Teacher's name: _____

Has your child ever been placed in special education classes? ○Yes ○No

If yes, please describe: _____

If yes, when did it begin? _____

Has your child ever been held back a grade? ○Yes ○No

If yes, which grade(s)? _____

Has your child ever received in-school or out-of-school suspensions? ○Yes ○No

If yes, please describe: _____

Please describe your child's current difficulties at school (if any): _____

_____

_____

_____

SOCIAL AND BEHAVIORAL INFORMATION

Does your child engage in behavior that could be dangerous to self or others? ○Yes ○No

If yes, please describe: _____

Does your child have specific fears? ○Yes ○No

If yes, please describe: _____

Does your child have unusual habits (e.g., thumb-sucking, pulling hair, etc.)? ○Yes ○No

If yes, please describe: _____

Does your child have difficulty with language? ○Yes ○No

If yes, please describe: _____

Does your child have difficulty with coordination? ○Yes ○No

If yes, please describe: _____

Does your child have difficulty with change? ○Yes ○No

If yes, please describe: _____

Does your child get along well with siblings? ○NA ○Yes ○No

Does your child get along well with other children? ○Yes ○No

DEVELOPMENTAL/MEDICAL INFORMATION

During pregnancy, was the child's mother on medication? ○Yes ○No

If yes, please describe: _____

During pregnancy, did the child's mother use drugs (including smoking and alcohol)? ○Yes ○No

If yes, please describe: _____

Was the child born prematurely? ○Yes ○No

Number of weeks gestation _____

Birth weight _____

Were there any complications during pregnancy or birth of the child? ○Yes ○No

If yes, please describe: _____

As a baby, did your child like being held? ○ Yes ○ No

As a baby, was your child overly fussy or had trouble with feeding or sleeping? ○ Yes ○ No

If yes, please describe: _____

At what age did your child…

Walk alone? _____ Speak first word? _____

Become toilet trained? _____

Has your child had any significant illnesses? ○ Yes ○ No

If yes, describe illnesses and ages at which they occurred: _____

_____

Has your child ever had any significant accidents or injuries? ○ Yes ○ No

If yes, describe and ages at which they occurred: _____

_____

Has your child had any surgeries or hospitalizations for medical reasons? ○ Yes ○ No

If yes, describe and ages at which they occurred: _____

_____

Does your child have a history of:

Ear Infections ○ Yes ○ No

Problems with visions ○ Yes ○ No

Dizzy or fainting spells ○ Yes ○ No

Seizures ○ Yes ○ No

Asthma ○ Yes ○ No

Other medical problems ○ Yes ○ No

If yes, please describe: _____

Is your child taking any medications at this time? ○Yes ○No

If yes, please list name and dosage (include over-the-counter medications):

_____

_____

Does your child currently have trouble with sleeping or appetite? ○Yes ○No

If yes, please describe: _____

How would you rate your child's current health (circle one)?

○ Excellent ○ Good ○ Fair ○ Poor

PSYCHOLOGICAL HISTORY

Please indicate if there is a family history of:

	Y/N	If yes, relationship to child
Alcoholism		
Drug Problems		
Schizophrenia		
Manic/Bipolar Disorder		
Depression		
Anxiety		
Suicide Attempt		
Antisocial Behavior		
Attention Problems		
Learning Problems		

Has your child ever received psychological services or been in counseling or therapy? ○Yes ○No

If yes, please describe: _____

Has your child been tested for intelligence, achievement, or symptoms of inattention or learning disabilities? ○Yes ○No

If yes, please describe and give age at which it occurred: _____

_____

Has your child been on medication for emotional or behavioral problems? ○Yes ○No

If yes, please describe and give age at which it occurred: _____

_____

Has your child ever used alcohol or illicit drugs? ○Yes ○No

If yes, please describe: _____

_____

Has your child ever been arrested or had contact with the police? ○Yes ○No

If yes, please describe and give age at which it occurred: _____

_____

Has your child ever been hospitalized for emotional or behavioral problems? ○Yes ○No

If yes, please describe and give age at which it occurred: _____

_____

Has your child ever been diagnosed with a mental disorder or functional limitation? ○Yes ○No

If yes, please describe: _____

_____

Describe your child's current sources of stress: _____

_____

Please list your child's assets/strengths: _____

_____

_____

Please provide any other information that may be useful to us in getting to know and in helping your child:

_____

_____

AVAILABILITIES

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

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am	Closed	Closed	Closed	Closed	Closed
9:00 am					
10:00 am					
11:00 am					
12:00 am					
1:00 pm					
2:00 pm					
3:00 pm					Closed
4:00 pm					Closed
5:00 pm	Closed		Closed		Closed
6:00 pm	Closed		Closed		Closed

AUTHORIZD SIGNATURES

_____ _____
Print Client's Name Client's date of birth

_____ _____
Client Signature (If age 13 or older) Date

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

_____ _____
Print Parent/Guardian/Authorized Adult's Name Relation to Client

_____ _____
Parent/Guardian/Authorized Adult Signature Date

Please note information will not be reviewed until your appointment, if you are in need of immediate care or are in a crisis situation please dial 911 or go to your local emergency room.

CONSENT FOR TREATMENT

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

Services

The Washington State University Psychology Clinic (Clinic) provides a variety of evidence-based mental health care services at affordable rates, including therapy and assessment for adults, children and adolescents, parents, veterans and their families in the greater Palouse area as well as Washington State through Telehealth. The clinic is a teaching, training, and research center supported by the WSU Psychology Department. Services are provided by doctoral level graduate students in Clinical Psychology (psychologists-in-training) who are under the supervision of WSU faculty members. WSU faculty members providing supervision are licensed clinical psychologists in the state of Washington with some also being licensed in the state of Idaho.

Psychotherapy usually takes between 10-25 sessions. If problems are more severe, complex or have lasted longer, treatment may take longer, up to one year. Given we are a training clinic, and new students join the clinic each academic year, we typically refer clients who require more than one year of treatment to other community mental health resources more well-suited to provide longer-term services. Although most of our therapy services are individual, on occasion we also offer couples and group therapy focused on particular issues. For both psychotherapy and assessment, we use a comprehensive intake process to determine the best approach.

If you are receiving therapy services, you will be asked to complete questionnaires to monitor your progress and identify potential barriers to treatment. This will be done online, using a secure outcome monitoring system. Initially, a larger battery of assessment measures will be administered. Over the course of your treatment the assessment measures will be specific to your presenting concerns. Your psychologist-in-training will share the results of these questionnaires with you at intervals so that the two of you can evaluate your progress toward your treatment goals and attend to issues that might be interfering with your work together. (Note: Clients age 13 and older will complete their own assessment of services. Parents/ guardians/ authorized adults will complete assessments for clients under the age of 13.)

Psychological assessments typically combine interviews, psychological testing, collateral information, and clinical observation to gain a comprehensive picture of a person's difficulties and needs. An assessment often requires several hours of testing and may stretch over several days. A comprehensive report with interpretations and recommendations is shared with you during a feedback session.

Scheduling, Cancellations, and Attendance

Appointments are scheduled directly by your psychologist-in-training or the patient services coordinator and can be arranged during business hours. The Clinic may suspend or terminate therapy services in response to two consecutive missed appointments or a pattern of excessive cancellations and/or missed appointments (less than 80% attendance). Similarly, missed assessment sessions might lead to discontinuation and placement on the bottom of our assessment waitlist. *You must call (509) 335-3587 to cancel appointments at least 24 hours in advance.* **Please Initial** _____

Payment

Except for very limited circumstances, the WSU Psychology Clinic provides services only on a self-pay cash basis. We are not billing private insurances and are not enrolled or contracted with Medicare, Medicaid (includes Medicare Advantage and Medicaid Managed Care Organization plans), or any other Federal health care program. The Psychology Clinic is neither permitted to bill these Federal health care programs nor are you permitted to seek reimbursement for the services received at the Psychology Clinic. If you have private health insurance or are insured through a Federal health care program (e.g., Medicare, Medicaid, Tricare, etc.) or their contracted managed care plans, you may be able to get mental health services fully covered by those programs by receiving treatment at a provider enrolled/contracted with those programs. If you have health insurance, you can reach out to your health plan and identify providers delivering covered services for their insureds.

You have the right to request a Good Faith Estimate (GFE) before receiving services at the clinic. The GFE may be adjusted during your intake session. Payment for services is expected at the time of your appointment. The intake fee for assessments ($25) is due at the intake session and is deducted from the overall fee of your assessment. The remainder of the fee is due at the first assessment session. We accept payment by cash, check, money order, or MasterCard and Visa. Credit card payments may be made in person at the clinic, over the phone, or online at our WSU Psychology Clinic webpage (https://psychologyclinic.wsu.edu/). Exceptions to payment procedures may apply if services are provided under one of our contracts. ***Late Payments:*** If you are unable to provide payment for two consecutive sessions and have not made alternative arrangements with us, your treatment may be suspended until payment is received. **Please Initial** _____

After Hours, Weekends, Holidays

If you feel you or your child are in crisis: Please call 988 or go to your local emergency room. Crisis hotlines include the following: Whitman County Crisis Line (1-888-544-9986), Alternatives to Violence 24-hour crisis lines in Pullman (509-332-4357) and Moscow (208-883-4357), or the National Suicide Prevention Lifeline (1-800-273-8255; TRS: 1-800-799-4889).

Parking

All parking spaces on campus require a permit. Illegal parking fines are costly. The nearest parking for the clinic is located in the Smith Center for Undergraduate Education Parking Garage. Parking for daytime use (5am-5pm Monday-Friday) is 2.00 per hour; parking for nighttime use (5pm-5am Monday-Friday) is 1.00 per hour. For questions or more information contact transportation services at 509-335-7275 or visit their website at transportation.wsu.edu.

Controlled Substances on Campus

WSU is a tobacco, nicotine, marijuana and other controlled substances free campus and prohibits the use of these products on the WSU Pullman campus.

Confidentiality

Clients have privileged communication with a psychologist or psychologists in training under Washington state and/or federal law with certain exceptions provided for under the law. See RCW 18.83.110. We understand that personal health information is very sensitive. We will not disclose a client's personal information to others without written consent unless the law requires or permits us to do so. See RCW 70.02; WAC 246-924-363.

Minors, Ages 13-17. Under Washington state law, minors ages 13-17 can request and receive outpatient mental health treatment without parental consent. See RCW 71.34.530. Under these circumstances we will not disclose a minor's mental healthcare records or information without their consent. For 13–17-year-old patients who are receiving care pursuant to parental/guardian request and payment, parents may also waive the right to have access to their child/ward's mental health records. We will not disclose a minor's treatment records without the written consent of the minor or the minor's parent unless the law requires or permits us to do so. See e.g., RCW 70.02.240.

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

a) To report a reasonable belief that a child has suffered abuse or neglect [RCW 26.44.030]. For reporting purposes, a child is anyone under the age of 18 [RCW 26.44.020].
b) To report a reasonable belief that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred [RCW 74.34.035 and RCW 5.60.060(9)(d)].
c) To prevent or minimize an imminent danger to the health or safety of the patient or any other person [RCW 5.60.060(9)(e)]. RCW 70.02.050(1)(c).
d) To comply with a court order or subpoena.
e) To obtain payment for the services being provided to you. If you have any questions or concerns about the reporting criteria, please talk with your therapist.

Supervision & Training. The Clinic is staffed by psychologists-in-training, who are students enrolled in the WSU Clinical Psychology Ph.D. program. Our psychologists-in-training practice under the supervision of licensed faculty members. For the purpose of supervision, training, and quality assurance, supervisors will review your records and video recordings of the treatment that you are receiving to assess the performance of our psychologists-in-training and to ensure you are receiving the appropriate treatment. Psychologists-in-training may also consult with one another regarding your treatment therapy in group supervision at the clinic. All psychologists-in-training are bound by the same privacy laws stated above. Psychologists-in-training will notify you of their training status and provide the name of their clinical supervisor. You may contact the supervisor directly by calling the WSU Psychology Clinic at (509)335-3587.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Your initials below acknowledge being offered a copy of our Notice of Privacy Practices. Copies are available in our front office and on our website at: https://psychologyclinic.wsu.edu/services-provided/patient-privacy/hipaa-statement/.

Please Initial _____

Audio/Video (A/V) Recording

Since we are a training clinic, faculty supervisors need to review the treatment that psychologists-in-training provide to clients. Audio/Video (A/V) recordings of psychotherapy or assessment sessions is essential for supervision, training, and quality assurance. A/V recordings are stored on an internal secure server, in a physically secure facility with additional password and firewall protections and can only be accessed by your therapist and supervisors. A/V recorded materials are erased at the end of supervision use, which typically occurs within two weeks of the treatment session and are not kept as part of your treatment record. Since A/V recordings are essential to the training mission of the clinic, we can not provide services if you are unwilling to permit A/V recordings. **Please Initial** _____

Paper & Electronic Records

Written and electronic mental health records are kept of the services provided to clients. Electronic health records are maintained on a secure server that is stored in a physically secure facility with additional password and firewall protections. Written records are stored in locked file cabinets within a locked room in the Clinic and are destroyed in a confidential manner after a period of ten years of inactivity.

Right to Refuse Treatment

You have the right to refuse treatment. If you consent to treatment, you have the right to withdraw your consent and discontinue treatment at any time. If you have questions or concerns about confidentiality, therapy, assessments, procedures, or any other aspect of the services you or your child/ward receive, please speak with your psychologist-in-training, their faculty supervisor, the clinic director, associate director, or the privacy officer. If you become dissatisfied with your treatment and would like a referral elsewhere, the Clinic will assist you with a referral to another therapist or agency.

Treatment Risks, Benefits & Alternatives

Possible Risks. Psychotherapy often engenders intense emotional experiences that accompany making changes, including feelings such as sadness, anxiety, guilt, anger, and frustration. You may also recall unpleasant memories or experience flashbacks to traumatic events. These feelings and memories may, for a time, bother you at work or in school. Making changes in your thoughts, feelings, and behaviors may feel disorienting or frightening at first and may affect sleep, appetite, energy, and ability to concentrate. Sometimes clients also experience disruptions in important relationships.

You will be asked to complete between-session assignments that take time and effort outside of sessions. It is also possible that despite the best efforts made by you and your therapist, you may not achieve the results you want, or that change may require more time than you initially intended. It is important that you carefully consider whether these potential risks are worth the possible benefits of treatment at this time.

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

Possible Benefits. Our clinic emphasizes psychological treatments designed for specific problems (e.g., depression, anxiety etc.) that have been shown to be effective for those problems. In rigorous random assigned controlled studies, these psychological treatments have been shown to be as, and in some cases, more effective than treatment with medications. Therapy often leads to significant reduction in symptoms such as depression or sadness, anger, anxiety, avoidance, hopelessness or helplessness. Often clients also report more satisfying relationships, more effective coping skills, improved stress management, solutions to specific problems, clarification of values and personal goals, and greater feelings of self-acceptance and confidence.

The benefits of assessment may include an increased accuracy of your mental health diagnosis which will lead to more effective treatment planning and enhance your understanding of how aspects of your personality, thoughts, feelings and behaviors may influence your progress. Neuropsychological assessment may identify the presence of specific learning disorders, memory problems, or other areas of strength and weakness which can help you locate specialized treatment or receive school or work accommodations.

Alternatives to Therapy Treatment. For any given problem, there are usually a number of different psychological treatments and medications that have also been shown to be effective. You should discuss these with your assigned student therapist if the first approach to treating your problem is not as effective as you would like.

Termination/Transfer of Care

The clinic reserves the right to terminate treatment if it becomes evident to the clinic director/associate director that the client: a) has care requirements that exceed the capabilities/expertise of the WSU Psychology Clinic b) will not benefit from continued service; c) no longer needs the services of the Clinic; or d) missed two consecutive therapy sessions or one assessment session, or has a pattern of excessive cancellations or missed appointments. In the case of termination of care, the clinic can provide you with a list of mental health providers in the community from whom you can seek assistance.

Please initial _____

Consent for Services

I understand and agree to the conditions described in this Consent for Treatment form and freely and voluntarily consent to receiving mental health services. I agree to pay for the services at the rate indicated on the Fee Schedule.

_____ _____

Print Client's Name | Client's Date of Birth

_____ _____

Client Signature (if age 13 or older) | Date

_____ _____

Print Parent/Guardian/Authorized Adult's Name | Relation to Client

_____ _____

Parent/Guardian/Authorized Adult Signature | Date

_____ Please initial if you waive the right to access your child/ward's health file (ages 13-17)

_____ _____

Clinician's Signature | Date

WSU PSYCHOLOGY CLINIC ADDENDUM

Appendix A: WSU Telehealth Consent Form

Informed Consent for Telemental Health Services

This Informed Consent for Telemental Health Services is an addendum to the standard consent for care agreement with the WSU Psychology Clinic. All aspects of our general WSU Psychology Clinic consent form (including the legally-mandated exceptions to confidentiality) remain in effect if you choose to receive telemental health services. Telemental Health (TMH) refers to counseling services provided remotely using telecommunications technologies such as secure video conferencing or telephone. TMH Services are conducted and documented in a confidential manner according to applicable laws and professional and ethical standards consistent with in-person services.

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

Please review the information below to make a decision regarding whether you (or your child) would like to consent to receive psychological services through TMH.

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

- As stated in our general consent form, we are a training clinic and our therapists are students enrolled in our doctoral clinical psychology program who are supervised in their work by licensed clinical psychologists. Psychologist-in-training will conduct sessions from the clinic or rare occasions from their home in a private location using a secure WSU-owned computer. Faculty supervisors may choose to join a zoom session in silent mode to supervise your student clinician. Zoom TMH sessions will be recorded using the clinic's internal server and reviewed using the same technology that is used for in-person sessions in the Clinic.

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

- We will be using a "HIPAA compliant" version of Zoom, a cloud-based video conferencing tool for TMH sessions. Zoom requires the use of a browser but does not require any software download. However, you will need to set up a free Zoom account for your sessions. This can be done by visiting www.zoom.us.

- In order to use Zoom to receive TMH services with your provider, you will need access to Internet service. You are advised to use a secure internet connection. For best picture and audio quality, a hardwired connection (via LAN cable) rather than a wireless one should be used if possible. If you do choose to use Wi-Fi it is best to use one that is secure, private and password protected. It is not appropriate to use public or shared Wi-Fi. Headphones add additional security.

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

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

permission for your provider to communicate with these emergency contacts about your care should an emergency arise.

- You will be responsible for the costs of TMH services. You can pay for therapy sessions through our webpage (WSU Psychology Clinic | Washington State), by sending a check, or by calling the WSU Psychology Clinic during business hours, providing your credit card number.

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

- You are only eligible for TMH services as long as you are physically located in the state of Washington or Idaho. State licensure laws prevent your clinician from being able to provide services if you are located in another state at the time of the session. If you anticipate that you will not be physically located in the state of Washington or Idaho during a planned session, you are responsible for letting your therapist know. Your therapist can provide you with referrals for continued services in your local area.

- Communication between TMH sessions is possible over the WSU Psychology Clinic's telephone at (509) 335-3587. Please leave a voice mail if you have questions. We will respond to your phone call in a timely manner. If you need to cancel your TMH session, please do so 24 hours in advance.

- Zoom links for your TMH sessions will be embedded in an email sent to your email address from BetterMind or meeting information can be relayed via phone.

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

_____	_____
Print Client's Name	Client's Date of Birth
_____	_____
Client Signature (if age 13 or older)	Date
_____	_____
Print Parent/Guardian/Authorized Adult's Name	Relation to Client
_____	_____
Parent/Guardian/Authorized Adult Signature	Date
_____	_____
Clinician's Signature	Date

WSU PSYCHOLOGY CLINIC ADDENDUM

Appendix B: Video Storage

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

This Informed Consent for video storage and is an addendum to the standard consent for care agreement with the WSU Psychology Clinic. All aspects of our general WSU Psychology Clinic consent form (including the legally-mandated exceptions to confidentiality) remain in effect.

We wanted to inform you that we are currently in the process of transitioning our videorecording and storage system. The new system will be cloud based, using the HIPAA compliant version of Zoom with increased security protections specifically developed to safeguard patient information.

This consent will last for the duration of the relationship with this clinic; I can withdraw my consent for psychological services at any time, and the WSU Psychology Clinic will work with me to find a suitable alternative.

_____ _____

Print Client's Name | Client's Date of Birth

_____ _____

Client Signature (if age 13 or older) | Date

_____ _____

Print Parent/Guardian/Authorized Adult's Name | Relation to Client

_____ _____

Parent/Guardian/Authorized Adult Signature | Date

_____ _____

Clinician's Signature | Date

WASHINGTON STATE UNIVERSITY
Department of Psychology

Research Study Parent Permission Form

Study Title: *Washington State University Psychology Clinic Research Database*

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

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

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

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

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

This form explains this clinical research database in more detail and your part in it if you decide to join the study. Please read the form carefully, taking as much time as you need. Ask the clinic staff to explain anything you don't understand. You may refuse to give permission, or you may withdraw your permission for your child to be in the study, for any reason. Your child will also be asked if he or she would like to take part in this study. Even if you give your permission, your child can decide not to be in the study or to leave the study at any time. There will be no penalty or loss of services or benefits to you or your child if you decide to not take part in the study or quit later. This study has been approved for human subject participation by the Washington State University Institutional Review Board (IRB).

What is this research study about?

As part of your standard clinical treatment/assessment, you (and possibly your child) will be asked to complete various measures. Completion of these measures is critical to enabling us to provide the best level of assessment and treatment services. The

completion of these measures is considered a non-research procedure; that is, it is just a standard part of clinical practice. You and your child will be able to complete these measures whether you agree to participate in this study or not.

If you agree to be in this research study, however, we would store your responses to these measures stripped of identifiers except for the subject ID code in a secure clinic research database. The information kept in the clinic research database will contain no personally identifying information. We refer to information that has had personally identifying information removed, as "de-identified." Signing this consent form will grant Clinic researchers access to the information that you and your child provide stripped of identifiers except for the subject ID code as part of routine clinical care. Clinic research that utilizes you and your child's archived information will have no impact on the type and/or duration of services you and your child receive at the Psychology Clinic.

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

We are asking your permission for your child to be in the study in the normal course of services provided at the clinic. Taking part in the study will no additional time for you or your child beyond the standard services that you receive at the clinic.

Your or your child cannot take part in this study if you do not agree to participate in the study or do not communicate well in English, as the measures are written in English.

What will I and my child be asked to do if we are in this research study?

If you and your child take part in the study, neither of you will be asked to do anything different than if you were not in the study. Your consent to this research project will just allow us to store data collected as part of our normal clinical services for future research. You or your child will not be asked to provide more time or effort that is not already part of standard Psychology Clinic procedure (e.g., completing an application, self-report measures, and the diagnostic interview). In other words, participating in the research project requires you to only provide the consent to researchers to use you and your child's data stripped of identifiers except for the subject ID code, but not any extra time or effort.

It should be noted that the clinic routinely records therapy sessions on videos. However, these videos are used for supervisory purposes in the doctoral training program in clinical psychology ONLY, are destroyed after one month, and would never

be made available to researchers. These recordings are not associated with any procedures covered in this permission form.

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

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

Are there any benefits to my child if he or she is in this research study?

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

Are there any risks to my child if he or she is in this research study?

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

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

You are only being asked permission for allowing researchers to access data. As the data are stripped of identifiers except for the subject ID code, there is no risk of breaching your confidentiality. If you choose not to provide permission, this information will be collected as part of your child's routine clinical care, but it will not be made available to investigators in any form at any time. Choosing not to provide permission will not affect your child's services in any way.

Will information about my child be kept private?

If you provide your consent, our Patient Services Coordinator, Rachelle Simons, will assign your child a research participant ID code. There will be a separate, password protected file stored on a secure, password-protected computer in a locked office at the WSU Psychology Clinic that will link the research participant ID code with your child's identifying information. Only Rachelle Simons, the Patient Services Coordinator, Walter Scott, the Clinic Director, and Conny Kirchenbaum, the Assistant Director, will have access to this master list linking your child's data with identifiers. The key will be maintained indefinitely. Individual researchers who are granted access to the clinic archival database stripped of identifiers except for the subject ID code will not have access to this id code. Therefore, the data they receive will be completely de-identified, and will have no way of being linked to your child's data.

Otherwise, the data for this study will be kept private and confidential to the extent allowed by federal and state law. No published results will identify you or your child, and your name and your child's name will not be associated with any findings. In the event of discovery of imminent harm to someone or abuse of child or vulnerable people (e.g., elderly, or disable person) during a client's services, the condition would be treated according to best practices in clinical psychology by the clinician and may be reported to appropriate authorities.

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

As part of standard procedure, the information you provide will be matched with a 8-digit identifier.

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

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

Are there any costs or payments for your child being in this research study?

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

What are my child's rights as a research study volunteer?

Your child's participation in this research project is completely voluntary. Your child may choose not to take part in this research, choose not to answer specific questions, or withdraw from having his/her information used in research at any time. There will be no penalty or loss of benefits to which you or your child are entitled if you choose not to give your permission for your child to take part or your child withdraws from the research project.

Who can I talk to if I have questions?

If you have questions about this study or the information in this form, please contact the researcher (Clinic Director) named above. If you have questions about your rights or your child's rights as a research participant, or would like to report a concern or complaint about this study, please contact the Washington State University Institutional Review Board at (509) 335-3668, or e-mail irb@wsu.edu, or regular mail at: Neill Hall 427, PO Box 643143, Pullman, WA 99164-3005.

What does my signature on this consent form mean?

Your signature on this form means that:

- You understand the information given to you in this form
- You have been able to ask the researcher questions and state any concerns
- The researcher has responded to your questions and concerns
- You believe you understand how information about your child might be used in research and the potential benefits and risks that are involved for your child.
- You understand that even if you give your permission, your child may choose not to take part in the study.

Statement of Consent

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

_____ _____

Signature of Parent Date

_____

Printed Name of Parent

Statement of Person Obtaining Informed Consent

I have carefully explained to the parent of the child being asked to take part in the study what will happen to their child.

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

I also certify that he or she:

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

_____ _____

Signature of Person Obtaining Consent Date

_____ _____

Printed Name of Person Obtaining Consent Person's Role in Research study

DO NOT ALTER OR DELETE ANY PART OF THE ADDENDUM

AUTHORIZATION TO CREATE, ACCESS, USE, AND SHARE (DISCLOSE) HEALTH INFORMATION FOR RESEARCH

Principal Investigator: Walter D. Scott	
Study Title: WSU Psychology Clinic Research Database	

By law, researchers must protect the privacy of health information about you. In this form the word "you" means both the person who takes part in the research and the person who gives permission for another person to be in the research. Researchers may use, create, or share your health information for research **only if you let them**. This form describes what researchers will do with your information. Please read it carefully. If you agree with it, please sign your name at the bottom. You will get a copy of this form after you have signed it.

If you sign this form, information will be shared with the people who conduct the research. In this form, all these people together are called "researchers." Their names will appear on the research consent form that you sign.

The researchers will use the health information only for the purposes named in this form.

1. **What "health information" includes**

   - All information about you that is collected during the research study. This might include the results of tests or exams that become part of the study records; diaries and questionnaires that you might be asked to fill out as part of the study and other records from the study.
   - All health information in your medical records that is needed for this research study. These might include the results of physical exams, blood tests, x-rays, diagnostic and medical procedures and your medical history.

2. **What the researchers may do with health information**

   The researchers may use and create health information about you for the study. They may also share your health information with certain people and groups. These may include:

   - The sponsor of the study Dr. Walter Scott, and its representatives
   - Government agencies, review boards, and others who watch over the safety, effectiveness, and conduct of the research. Other researchers when a review board approves the sharing of the health information.
   - Your health insurer if they are paying for care provided as part of the research study.
   - Others, if the law requires.

3. **Removing your name from health information**

   The researchers may remove your name (and other information that could identify you) from your health information. No one would know the information was yours.

   If your name is removed, the information may be used, created, and shared by the researchers and sponsor as the law allows. (This includes other research purposes.) This form would no longer limit the way the researchers use, create, and share the information.

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4. How the researchers protect health information

The researchers [and sponsor] will follow the limits in this form. If they publish the research, they will not identify you unless you allow it in writing. These limitations continue even if you take back this permission.

5. After the researchers learn health information

The limits in this form come from a federal law called the Health Insurance Portability and Accountability Act. This law applies to your doctors and other health care providers.

Once the researchers get your health information, this law may no longer apply. But other privacy protections will still apply.

6. Storing your health information

Your health information may be added to a database or data repository. This permission will end when the database or data repository is destroyed.

7. Please note

You do not have to sign this permission ("authorization") form. If you do not, you may not be allowed to join the study. You may change your mind and take back your permission at any time. To take back your permission, write to: email: walter.scott@wsu.edu

If you do this, you may no longer be allowed to be in the study. The researchers will keep any information in the study record they already collected.

Your authorization will expire when the goals of the study have been met.

During the study, you will not be allowed to see your health information that the researchers may place in your medical record. After the study is finished, you may see this information.

8. Your signature

If I have not already received a copy of the Privacy Notice, I may request one. If I have any questions or concerns about my privacy rights, I should contact the WSU IRB at 509-335-3668.

I am the subject or am authorized to act on behalf of the subject. I have read this information, and I will receive a copy of this form after it is signed.

I agree to the use, creation, and sharing of my health information for purposes of this research study

_____	_____
Signature of research subject or subject's legal representative	Date
_____	_____
Printed name of research subject or subject's legal representative	Representative's relationship to subject

Version: February 2018

FEE WORKSHEET

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

Client Name:_____ **Client #:** _____
Parent/Guardian/Authorized Adult: _____ **Relationship to Client:** _____

The WSU Psychology Clinic provides therapy and assessment services on a sliding scale fee that is based on your household income or your status as a full-time student (Please see fee charts on the back of this handout). We do not submit claims to third-parties such as health plans or insurance companies for services we render to clients. More specifically, the Psychology Clinic is not enrolled or contracted with Medicare, Medicaid (including Medicare Advantage or Medicaid Managed Care Organization plans), or any other Federal health care program. The Psychology Clinic is neither permitted to bill Federal health care programs nor are you permitted to seek reimbursement for the services received at the Psychology Clinic. Each client or their guarantor (e.g., parent or guardian) is generally required to pay out of pocket (i.e., cash pay) for the mental health services received at the Psychology Clinic.

Although we do not bill insurance, we are required to note the insurance status of our clients.

Do you have health insurance? ◯ Yes ◯ No

- If yes, do you have: _☐ Medicaid _☐ Medicare ☐ Tricare _☐ Private Health Plan (Regence, Aetna, Kaiser) ☐ Other:_____

Clients with Health Insurance: If you have health insurance through a Federal health care program (e.g., Medicare, Medicaid, Tricare, etc. or their contracted managed care plans) or other health insurance, you may be able to get mental health services fully covered by those programs/plans by receiving treatment at a provider enrolled/contracted with those programs/plans. If you have health insurance, you can reach out to your health plan and identify providers delivering covered services for their insureds.

Proof of monthly/annual net income or student ID is required at the time of the intake interview if you wish to be considered for the sliding scale fee. We will not keep a copy of these documents but your therapist will verify your income. If you do not provide proof of income or student status you will be charged at the highest rate for services.
Note: All confidential information on your income document **should be redacted (e.g., marked out with heavy black ink) before the therapist views it. This includes social security number, bank account numbers, etc**.
Fees are due at the time services are rendered. In cases of extreme financial hardship, lower fees may be negotiated on a temporary basis with the approval of the Clinic Director. Please discuss this process with your therapist

Fee Agreement:
I, _____, the Client (or Parent/Guardian/Authorized Adult), request that the Psychology Clinic provide professional services to me or my child/ward, and I agree to pay the fee of $_____ per hour (or $_____ flat assessment rate) for these services. I acknowledge that I am personally responsible for these professional fees for services provided by the Clinic to me or my child/ward.

_____

Client Signature (or Parent/Guardian/Authorized Adult if Client is under the age of 18) **Date**

Over

Therapy Services

Student Fee: Fulltime students are eligible for a lower fee of $10/hour.

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

		Number of Family members and Rate per hour	
Monthly income	**Annual income**	**1 -2**	**3+**
0-3,750	0-44,999	20.00	15.00
3,751-7,083	45,000-84,999	50.00	40.00
7,084 +	85,000 +	80.00	60.00
Intake interviews are scheduled for 2 hours and will be charged at two times the established fee for sessions. 2 missed appointments in a row or less than 80% attendance may result in termination of sessions.			

Assessment Services

Please circle your monthly or annual income and the type of assessment you are seeking on the chart below. **Note: $50.00 fee per additional area assessed.**

	Annual Income		
Assessments	**$ 0-44,999**	**$45,000-84,999**	**$85,000+**
Learning Disability	$350.00	$450.00	$550.00
Attention Deficit/Hyperactivity	$350.00	$450.00	$550.00
Autism Assessment	$350.00	$450.00	$550.00
Intellectual Ability	$350.00	$450.00	$550.00
Neuropsychological	$350.00	$450.00	$550.00
Psychological Evaluation/Diagnostic Clarification	$250.00	$350.00	$450.00
Intake appointments Fee (included in total fee listed above)	$25.00	$25.00	$25.00

Staff use only

Verification of Income:

Document Viewed: ___ Income Tax Return for the Year _____ Annual Income: _____

___Other (Please specify: _____)

Name of Person Verifying Documentation: _____

Signature of Person Verifying Documentation: _____

Date of Verification: _____