For Office Use Only
Client ID #: _____

WSU PSYCHOLOGY CLINIC BACKGROUND QUESTIONS

Welcome to the WSU Psychology Clinic. If YOU are the client, please complete all relevant information accordingly. If you are the PARENT/GUARDIAN/AUTHORIZED ADULT for a child or adolescent client, please complete all client information for your child/ward as well as information relevant to you as the parent/guardian/authorized adult.

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.

What is your full name? _____
Preferred Name:_____
Preferred Pronouns:_____
What is your mailing address?
_____
_____
_____

What is the best phone number to reach you at? _____

May we leave a message at this number? ○Yes ○No

What is the best email address to reach you at? _____

May we use email to send outcome monitoring questionnaires and telehealth meeting links via CHADIS? ○Yes ○No

Please place check marks by all of the times you are available to attend therapy 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 pm					
1:00 pm					
2:00 pm					
3:00 pm					Closed
4:00 pm	Closed		Closed		Closed
5:00 pm	Closed		Closed		Closed
6:00 pm	Closed		Closed		Closed

Emergency contact person: _____
Relationship to contact person: _____
Phone number: _____
Address: _____
_____

What is your date of birth? _____ Your age? _____

What is your gender identity? (Check all that apply)

- o Female
- o Male
- o Transgender
- o Self-Identify _____

Do you consider yourself to be: (Check all that apply)

- o Heterosexual/Straight
- o Lesbian
- o Gay
- o Bisexual
- o Questioning
- o Self-identify_____

What is your race/ethnicity? (Check all that apply)

- o African American/Black
- o American Indian or Native American
- o Asian American/Asian
- o Hispanic/Latino/a
- o Native Hawaiian or Pacific Islander
- o Multi-racial
- o White
- o Self-Identify _____

How would you identify your religious affiliation?

- o Agnostic
- o Atheist
- o Buddhist
- o Catholic
- o Christian
- o Hindu
- o Jewish
- o Muslim
- o No Preference
- o Prefer not to answer
- o Other (please specify)_____

To what extent does your religious or spiritual preference play an important role in your life?

- o Very Important
- o Important
- o Neutral
- o Unimportant
- o Very Unimportant

In what state/country were you born? _____

Do you have siblings? o Yes o No

If yes, how old are they? _____

What is your relationship status?

- o Single
- o Serious dating or committed relationship
- o Civil Union, domestic partnership, or equivalent
- o Married
- o Separated
- o Divorced
- o Widowed

For Office Use Only
Client ID #: _____

Do you have children? ○Yes ○ No
If yes, how many? _____ What are their ages? _____

With whom do you live? (Check all that apply)
- o Alone
- o Spouse, partner, or significant other
- o Roommate(s)
- o Children
- o Parent(s) or Guardian(s)
- o Family other
- o Other (please specify) _____

How would you describe your financial situation right now?
- o Always stressful
- o Often stressful
- o Sometimes stressful
- o Rarely stressful
- o Never stressful

How would you describe your financial situation growing up?
- o Always stressful
- o Often stressful
- o Sometimes stressful
- o Rarely stressful
- o Never stressful

Are you currently receiving social security disability benefits? ○Yes ○ No
If yes, please specify your disability: _____

Are you currently receiving any other entitlement benefits? ○Yes ○ No
If yes, check all that apply
- o AFDC Welfare
- o Food stamps
- o Housing assistance
- o Medical assistance
- o Veterans benefits
- o Other (please specify)_____

Have you ever been enlisted in a branch of the U.S. military? ○Yes ○ No

Are you currently employed? ○Yes ○ No
If yes, what is your current occupation? _____ How long? _____

Are you currently a student? ○ Yes ○ No
If yes, at which university? _____
What is your year? _____ What is your major? _____

Do you participate on an athletic team that competes with other Colleges or Universities?
○Yes ○ No

What is your highest level of education completed?

- o Did not attend high school
- o Some high school
- o High school degree
- o Some college
- o Trade school degree
- o Associate's degree
- o Bachelor's degree
- o Master's degree
- o Doctorate

Are you currently, or do you intend to be, involved in any litigation or court proceedings which may eventually involve your therapist at the Psychology Clinic or use the results of this assessment or services? o Yes o No

---

MEDICAL HISTORY

What is your height? _____

What is your weight? _____

Do you regularly visit a physician or clinic to receive medical care or physical examinations? o Yes o No
What is the name of primary care physician? _____
What is the approximate date of your last physical exam? _____

At the present time, how would you rate your overall physical health?

- o Excellent
- o Good
- o Fair
- o Poor

Have you had a major surgery in the last five years? o Yes o No
If yes, please specify approximate dates of surgeries and types of surgery:
_____
_____
_____

Have you been hospitalized in the last five years for any major physical disease or condition other than the surgeries you listed previously? o Yes o No
If yes, please specify approximate dates of hospitalizations and physical problems:
_____
_____
_____

Are you currently being treated for any physical disease or condition? o Yes o No
If yes, please specify: _____

Have you ever had a concussion or head injury? o Yes o No
If yes, did you lose consciousness? o Yes o No

Please specify the approximate dates of head injuries:

_____

_____

Are you currently taking any medications for physical complaints? ○ Yes ○ No

If yes, please specify the medication, dosage, and how often you take it:

_____

_____

Have you ever been diagnosed with any of the following? (Check ALL that apply.)

_____ a. Hyperthyroidism
_____ b. Heart arrhythmia
_____ c. Hypothyroidism
_____ d. Pheochromocytoma
_____ e. Hypoglycemia
_____ f. Hyperparathyroidism
_____ g. Pulmonary embolism
_____ h. Pneumonia
_____ i. Chronic obstructive pulmonary disease
_____ j. Hyperventilation
_____ k. B-12 deficiency
_____ l. Congestive heart failure
_____ m. Porphyria
_____ n. Central Nervous System neoplasm
_____ o. Vestibular dysfunction
_____ p. Encephalitis
_____ q. Diabetes
_____ r. Heart problems
_____ s. High blood pressure
_____ t. Low blood pressure
_____ u. Epilepsy
_____ v. Cancer
_____ w. Hormone problem
_____ x. Asthma
_____ y. Respiratory problems
_____ z. Migraines
_____ aa. Stroke
_____ ab. Ulcers
_____ ac. Gastrointestinal problems
_____ ad. Blood disorders
_____ ae. HIV/AIDS
_____ af. Irritable bowel syndrome
_____ ag. Fibromyalgia
_____ ah. Food allergies

Have any of your direct relatives been diagnosed with any of these problems? (Check ALL that apply.)

_____ a. Hyperthyroidism
_____ b. Heart arrhythmia
_____ c. Hypothyroidism
_____ d. Pheochromocytoma
_____ e. Hypoglycemia
_____ f. Hyperparathyroidism
_____ g. Pulmonary embolism
_____ h. Pneumonia
_____ i. Chronic obstructive pulmonary disease
_____ j. Hyperventilation
_____ k. B-12 deficiency
_____ l. Congestive heart failure
_____ m. Porphyria
_____ n. Central Nervous System neoplasm
_____ o. Vestibular dysfunction
_____ p. Encephalitis
_____ q. Diabetes
_____ r. Heart problems
_____ s. High blood pressure
_____ t. Low blood pressure
_____ u. Epilepsy
_____ v. Cancer
_____ w. Hormone problem
_____ x. Asthma
_____ y. Respiratory problems
_____ z. Migraines
_____ aa. Stroke
_____ ab. Ulcers
_____ ac. Gastrointestinal problems
_____ ad. Blood disorders
_____ ae. HIV/AIDS
_____ af. Irritable bowel syndrome
_____ ag. Fibromyalgia
_____ ah. Food allergies

PSYCHIATRIC HISTORY

What concerns are currently bringing you to treatment? (Check all that apply.)

o Academics
o Alcohol or other drugs
o Anxiety/Panic
o Depression
o Discrimination
o Domestic violence
o Eating problems
o Friends/Social
o Harassment/Stalking
o Homicidal thoughts
o Irritability/Anger
o Learning disability
o Medical/Physical concerns
o Psychiatric medications
o Racial/Ethnic issues
o Relationships

- o Religious/Spiritual
- o Self-esteem/Self-confidence
- o Sexual concerns
- o Sexual orientation
- o Suicidal thoughts
- o Trauma
- o Other, Please specify: _____

Please describe the concerns that bring you to the Psychology Clinic at this time?

_____
_____
_____

Are you currently receiving any of the following psychological services? (Check all that apply.)

- o Group psychotherapy
- o Individual outpatient psychotherapy
- o Psychiatric care
- o Pastoral counseling
- o Partial hospitalization (Psych Rehab)
- o Residential care (CRR, LTSR)
- o Substance abuse treatment
- o Other _____

Have you ever been hospitalized for anxiety, depression, substance abuse, or any other emotional or psychological problems? ○Yes ○No

If yes, please specify the approximate dates of hospitalization and the reason for each hospitalization: _____
_____
_____

Have you ever received any outpatient treatment for any emotional or personal difficulties?
○Yes ○No

If yes, please specify the approximate dates of past therapies and the reason for therapy:
_____
_____
_____

Are you currently taking any medications for anxiety, depression, pain, or any other emotional problem? ○Yes ○No

If yes, please specify the medications, dosage, and how often you take it:
_____
_____

Who is prescribing these medications? _____

How often do you use alcohol? (Check one.)

- o Never
- o Once a month
- o Once a week
- o 2-3 times a week
- o 4 or more times a week

Number of drinks per occasion?

- o 1 or 2
- o 3 or 4
- o 5 or 6
- o 7, 8 or 9
- o 10 or more

Have you ever used marijuana? ○ Yes ○ No

If yes, over the last two weeks. How many times have you smoked marijuana?

- o None
- o Once
- o Twice
- o 3 to 5 times
- o 6 to 9 times
- o 10 or more times

Have you ever used any illicit substances or abused any prescription medications or household substances? ○ Yes ○ No

If yes, please specify. _____

_____

Are you currently using any illicit substances or abusing any prescription medications or household substances? ○Yes ○No

If yes, please specify. _____

_____

Please indicate how much you agree with this statement: "I get the emotional help and support I need from my family."

- o Strongly disagree
- o Somewhat disagree
- o Neutral
- o Somewhat agree
- o Strongly agree

Please indicate how much you agree with this statement: "I get the emotional help and support I need from my social network (e.g., friends & acquaintances)."

- o Strongly disagree
- o Somewhat disagree
- o Neutral
- o Somewhat agree
- o Strongly agree

Who referred you for this assessment?

- o Counseling and Psychological Services
- o Family
- o Friend
- o Morgan Center
- o Physician

  Specify name: _____
- o Self

TELEMENTAL HEALTH

Telemental Health (TMH) refers to counseling/assessment services provided remotely using telecommunications technologies such as secure video conferencing or telephone. You may be receiving services outside of the Clinic and there are some cases that may not be appropriate for TMH. Some additional requirements are listed below:

Do you have a private space to use during sessions? ◯ Yes ◯ No
Do you have access to secure, private, password protected internet? ◯ Yes ◯ No
Do you have a device capable to running Zoom during TMH sessions? ◯ Yes ◯ No
Do you have access to a phone as a backup? ◯ Yes ◯ No
Will you be in the state of Washington/Idaho during your planned sessions? ◯ Yes ◯ No

It is possible that receiving TMH services will not be an effective form of care 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.

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, including therapy and assessment to adults, children and adolescents, parents, veterans and their families in the greater Palouse area at affordable rates. 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 psychologists in the state of Washington with some also being licensed in the state of Idaho. A limited number of services are also offered by WSU faculty members.

Psychotherapy usually takes between 10-20 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. Although most of our therapy services are individual, we also offer couple's and group therapy focused on particular issues. For both psychotherapy and assessment, we use a comprehensive intake process to determine the best treatment.

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 the secure CHADIS 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 goals for treatment, 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.) You will also receive your Zoom links for telemental health sessions through CHADIS or through Titanium, our scheduling software.

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. Messages regarding treatment, billing, and cancellations can be left at (509) 335-3587 at any time.

The Clinic may suspend or terminate therapy or assessment services in response to two consecutive missed appointments or a pattern of excessive cancellations and/or missed appointments (less than 80% attendance). *You must call (509) 335-3587 to cancel appointments at least 24 hours in advance*. Missed therapy appointments or late cancellations (less than 24 hours prior to your appointment) are charged at

your established session rate. Missed or late cancelled assessment appointments will be charged a $25.00 fee. **Please Initial _____**

Payment

The WSU Psychology Clinic provides services on a self-pay basis and does not bill insurance companies. Payment for services is expected at the time of your appointment. The intake fee for assessments is due at the intake session and is deducted from your overall expense. 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 paid 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 911, or go to your local emergency room. Crisis hotlines include the following: Psychology Clinic crisis line (800-663-2810), Alternatives to Violence 24-hour crisis lines in Pullman (509-332-4357) and Moscow (208-883-4357).

Parking

All parking spaces on campus require a permit. Illegal parking fines are costly. The Clinic will provide parking for the duration of your therapy or assessment appointment in the Smith Center for Undergraduate Education Parking Garage. Contact the clinic at 509-335-3587 with any questions regarding parking.

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. 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. You will receive a copy of our *Notice of Privacy Practices*, which outlines in detail how we use and disclose your protected health information.

Minors, Ages 13-17. Under Washington state law, minors, ages 13-17, can request and receive outpatient mental health treatment without parental consent. See RCW 71.34.530. Under these circumstances we will not disclose a minor's health files without their consent. Parents of 13-17 year-old minors can also waive the right to have access to their child/ward's health files. 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 and health care operations. 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 direct 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.

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 are unlikely to be able to provide services if you are unwilling to permit A/V recordings. **Please Initial _____**

Paper & Electronic Records

Written and electronic 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. You may request a copy of your health records as outlined in our *Notice of Privacy Practices*.

Right to Refuse Treatment

You have the right to refuse treatment. If you consent to treatment, you have the right to withdraw your consent and discontinue treatment at any time. If you have questions or concerns about confidentiality, therapy, assessments, procedures, or any other aspect of the services you or your child/ward receive, please speak with your 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 making changes in your life at this time.

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

Possible Benefits. Our clinic emphasizes psychological treatments that have been shown to be effective for specific problems for most people who receive these treatments. In rigorous controlled studies, these psychological treatments have been shown to be as, and in some cases even more, effective than treatment with medications. Therapy often leads to significant reductions in symptoms such as depression or sadness, anger, anxiety, 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 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 psychological treatments that have been shown to be effective. You should discuss these with your 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 sessions or has a pattern of excessive cancellations or missed appointments. In the case of termination of care, the clinic will provide you with a list of mental health providers in the community from whom you can seek assistance. **Please initial _____**

Consent for Services

I understand and agree to the conditions described in this Consent for Treatment form and freely and voluntarily consent to receiving mental health services. I agree to pay for the services received 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

Appendix A: WSU Telehealth Consent Form

WSU PSYCHOLOGY CLINIC ADDENDUM

Informed Consent for Telemental Health Services

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

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

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

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

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

- As stated in our general consent form, we are a training clinic and our therapists are students enrolled in our doctoral clinical psychology program who are supervised in their work by licensed clinical psychologists. Students will conduct sessions from the clinic or in a few cases 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 to avoid no-show fees.

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

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

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

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (if applicable): _____

Signature of Patient or Parent/Guardian: _____ Date: _____

Signature of Provider: _____ Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

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

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

Protected Health Information

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

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

Uses and Disclosures

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

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

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

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

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

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

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vulnerable adult has occurred [RCW 74.34.035 and RCW 5.60.060(9)(d)].
- To prevent or minimize an imminent danger to the health or safety of the patient or any other person [RCW 5.60.060(9)(e)].
- To comply with a court order or subpoena.

Your Rights

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

Our Duties

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

Complaints

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

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

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

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

Acknowledgment of Receipt

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

_____	_____
Print Client's Name	Client's date of birth
_____	_____
Client Signature (If age 13 or older)	Date

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

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

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WASHINGTON STATE UNIVERSITY
Department of Psychology

Research Study Consent 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 ACCESS TO SERVICES

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

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

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

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

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

What is this research study about?

As part of your standard clinical treatment/assessment, you will be asked to complete various measures. Completion of these measures is critical to enabling us to provide you the best level of care. Your completion of these measures is considered a non-

research procedure; that is, it is just a standard part of our normal clinical practice. And you will be able to complete these measures whether you agree to participate in this study or not.

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

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

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

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

It should be noted that the clinic routinely records therapy sessions on videos. However, these videos are used for supervisory purposes in the doctoral training program

in clinical psychology ONLY, are destroyed after one month, and would never be made available to researchers. These recordings are not associated with any procedures in this proposal.

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

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

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

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

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

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

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

code, and used by Clinic researchers.

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

Will my information be kept private?

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

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

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

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

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

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

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

Who can I talk to if I have questions?

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

Washington State University Institutional Review Board (IRB) at (509) 335-3668, or e-mail irb@wsu.edu, or regular mail at: Washington State Institutional Review Board, Office of Research Assurances, PO Box 643143 Neil 427, Pullman, WA 99164-3143.

What are my rights as a research study volunteer?

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

What does my signature on this consent form mean?

Your signature on this form means that:

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

Statement of Consent

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

_____ _____

Signature of Participant Date

_____

Printed Name of Participant

Statement of Person Obtaining Informed Consent

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

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

I also certify that he or she:

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

_____ _____

Signature of Person Obtaining Consent Date

FEE WORKSHEET

Psychology Clinic
Washington State University
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. We do not submit claims to insurance companies on your behalf but we can provide you with a receipt of services. Proof of annual net income/monthly 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. **Note: All confidential information on your document should be redacted (e.g., marked out with heavy black ink) before the therapist views it. This includes social security number, bank account numbers**, etc. The Psychology Clinic will not keep a copy of your document but your therapist will view it only to verify income. If you do not provide proof of income or student status you will be charged at the highest rate for services.

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.

Therapy Services

Student Fee: Fulltime students are eligible for our lowest 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	4	5 or more
0-1,416	0-16,999	10.00	10.00	10.00	10.00	10.00
1,417-1,916	17,000-22,999	15.00	15.00	15.00	15.00	15.00
1,917-2,833	23,000-33,999	20.00	15.00	15.00	15.00	15.00
2,834-3,750	34,000-44,999	30.00	20.00	20.00	15.00	15.00
3,751-4,583	45,000-54,999	40.00	20.00	20.00	20.00	15.00
4,584-5,416	55,000-64,999	50.00	40.00	30.00	20.00	20.00
5,417-6,250	65,000-74,999	60.00	50.00	40.00	25.00	20.00
6,251-7,083	75,000-84,999	70.00	60.00	50.00	30.00	25.00
7,084 +	85,000 +	80.00	70.00	60.00	40.00	35.00
Intake interviews are scheduled for 2 hours and will be charged at two times the established fee for sessions Missed therapy appointments or late cancellations (less than 24-hour notice) are charged at the established fee.						

Assessment Services

Student Fee: Fulltime students are eligible for our lowest fee. Please circle the lowest rate of the assessment you are seeking on the chart below.

Community Members Sliding Fee Scale: Please circle your monthly or annual income and the type of assessment you are seeing on the chart below.

NOTE: This fee schedule does not apply to clients who are referred by agencies with whom the Psychology Clinic has a contract to provide services. In these instances, the agency and not the client pays for services.

Assessment Services	**Annual Income**								
	0-16,999	17,000-22,999	23,000-33,999	34,000-44,999	45,000-54,000	55,000-64,999	65,000-74,999	75,000-84,999	85,000+
Learning Disability and Attention Deficit/Hyperactivity Assessment	$250.00	$275.00	$300.00	$350.00	$400.00	$450.00	$500.00	$550.00	$600.00
Autism Assessment	$400.00	$425.00	$450.00	$500.00	$550.00	$600.00	$650.00	$700.00	$750.00
Emotional and Behavioral Assessment	$250.00	$275.00	$300.00	$350.00	$400.00	$450.00	$500.00	$550.00	$600.00
Intellectual Disability Assessment	$250.00	$275.00	$300.00	$350.00	$400.00	$450.00	$500.00	$550.00	$600.00
Gifted Assessment	$100.00	$125.00	$150.00	$175.00	$200.00	$225.00	$250.00	$275.00	$300.00
Memory Notebook Training	$10/hour	$15/hour	$20/hour	$25/hour	$30/hour	$35/hour	$40/hour	$45/hour	$50/hour
Diagnostic Clarification Assessment	$200.00	$200.00	$200.00	$225.00	$225.00	$225.00	$250.00	$250.00	$250.00
Neuropsychological Assessment	$300.00	$325.00	$350.00	$375.00	$450.00	$475.00	$500.00	$550.00	$600.00
Faculty Services	$75.00/hour	$75.00/hour	$100.00/hour	$100.00/hour	$125.00/hour	$125.00/hour	$150.00/hour	$150.00/hour	$150.00/hour
Missed appointments/late cancellations	$25.00	$25.00	$25.00	$25.00	$25.00	$25.00	$25.00	$25.00	$25.00
Clinical Intake Interview (1-2 hrs.)	This is a flat fee of $25.00 due at the time of the clinical interview. It is included in the assessment costs below and the remainder of the fee is due on the first day of testing.								

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 financially responsible for services provided by the Clinic to me or my child/ward. I understand that contracted agencies may make payments on this account. I authorize the Clinic to disclose my personal health information to federal and state agencies as necessary to secure payment for services paid for by those agencies.

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