

# WSU PSYCHOLOGY CLINIC

## APPLICATION FOR SERVICES & BACKGROUND QUESTIONS

### (Adult Services)

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PLEASE complete all relevant information accordingly. Information will not be reviewed until your appointment, if you are in need of immediate care or are in a crisis situation, please dial 988 or go to your local emergency room.

Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Pronouns: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Phone: \_\_\_\_\_

May we leave a message at this number?

Yes No No

Email: \_\_\_\_\_

May we communicate with you via email?

Yes No

Mailing Address: \_\_\_\_\_

#### What types of services are you seeking?

- Individual Therapy
- ADHD Assessment
- Learning Disability Assessment
- Autism Assessment
- Neuropsychological Assessment
- Diagnostic Clarification/Psychological Assessment
- Other \_\_\_\_\_

#### Were you referred to our office by:

- Department of Social and Health Services (DSHS)
- Department of Vocational Rehabilitation (DVR)
- Nez Perce Tribe Vocational Rehabilitation (NPVR)
- WA State Dept. of Veterans Affairs
- Nimiipuu Behavioral Health (NBH)
- Farm Aid/WRASAP Program
- School district \_\_\_\_\_
- Physician

Specify name: \_\_\_\_\_

#### Do you intend to use the results of your assessment or our services for any court proceedings?

Yes No

*If yes, please notify our staff and clinician immediately as some services may not be appropriate due to our training clinic status.*

#### Do you have health insurance? Yes No

If yes, do you have:

- Medicaid
- Medicare
- Tricare
- Private Health Plan (Regence, Aetna, Kaiser...)

*If you are enrolled with Medicare, please notify our staff and clinician immediately as some services may not be appropriate due to our training clinic status.*

**In what state/country were you born?** \_\_\_\_\_

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

- Female
- Male
- Transgender
- Self-Identify \_\_\_\_\_
- Prefer not to answer

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

- Heterosexual/Straight
- Lesbian
- Gay
- Bisexual
- Questioning
- Self-identify \_\_\_\_\_
- Prefer not to answer

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

- African American/Black
- American Indian or Native American
- Asian American/Asian
- Hispanic/Latino/a
- Native Hawaiian or Pacific Islander
- Multi-racial
- White
- Self-Identify \_\_\_\_\_
- Prefer not to answer

**How would you identify your religious affiliation?**

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

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

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

**What is your relationship status?**

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

**Do you have children?** Yes No

If yes, how many? \_\_\_\_\_ What are their ages? \_\_\_\_\_

**With whom do you live? (Check all that apply)**

- Alone
- Spouse, partner, or significant other
- Roommate(s)
- Children
- Parent(s) or Guardian(s)
- Family other
- Other (please specify) \_\_\_\_\_

**How would you describe your financial situation right now?**

- Always stressful
- Sometimes stressful
- Never stressful

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

**Are you a family member (Spouse, Parent, Child) of a Veteran?** Yes No

**Are you currently employed?** Yes No  
If yes, what is your current occupation? \_\_\_\_\_

**What is your highest level of education completed?**

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

**Are you currently a student?** Yes No  
If yes, at which university? \_\_\_\_\_  
What is your year? \_\_\_\_\_ What is your major? \_\_\_\_\_  
Current GPA? \_\_\_\_\_

**Emergency Contact**

**Name:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Relationship to client:** \_\_\_\_\_

**MEDICAL HISTORY**

**At the present time, how would you rate your overall physical health?**  
 Excellent       Good       Fair       Poor

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

- \_\_\_\_\_ a. Hyperthyroidism/ Hypothyroidism
- \_\_\_\_\_ b. Hypoglycemia
- \_\_\_\_\_ c. Hyperventilation
- \_\_\_\_\_ d. B-12 deficiency
- \_\_\_\_\_ e. Diabetes
- \_\_\_\_\_ f. Heart problems
- \_\_\_\_\_ g. High/ Low blood pressure
- \_\_\_\_\_ h. Epilepsy/seizure
- \_\_\_\_\_ i. HIV/AIDS
- \_\_\_\_\_ j. Cancer
- \_\_\_\_\_ k. Hormone problem
- \_\_\_\_\_ l. Asthma
- \_\_\_\_\_ m. Respiratory problems
- \_\_\_\_\_ n. Stroke
- \_\_\_\_\_ o. Migraines
- \_\_\_\_\_ p. Ulcers
- \_\_\_\_\_ q. Gastrointestinal problems
- \_\_\_\_\_ r. Fibromyalgia
- \_\_\_\_\_ s. Food allergies
- \_\_\_\_\_ t. Difficulty hearing
- \_\_\_\_\_ u. Nearsighted/Farsighted
- \_\_\_\_\_ v. Traumatic brain injury
- other \_\_\_\_\_

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

**Are you currently taking any medications?** Yes No

If yes, please specify the medication and what it is used for

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Who is prescribing these medications?

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#### PSYCHIATRIC HISTORY

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

- |  |   |
|--|---|
| <input type="radio"/> Academics              | <input type="radio"/> Learning disability         |
| <input type="radio"/> ADHD/LD                | <input type="radio"/> Medical/Physical concerns   |
| <input type="radio"/> Alcohol or other drugs | <input type="radio"/> Memory issues               |
| <input type="radio"/> Anxiety/Panic          | <input type="radio"/> Racial/Ethnic issues        |
| <input type="radio"/> Depression             | <input type="radio"/> Relationships               |
| <input type="radio"/> Discrimination         | <input type="radio"/> Religious/Spiritual         |
| <input type="radio"/> Domestic violence      | <input type="radio"/> Self-esteem/Self-confidence |
| <input type="radio"/> Eating problems        | <input type="radio"/> Sexual concerns             |
| <input type="radio"/> Friends/Social         | <input type="radio"/> Sexual orientation          |
| <input type="radio"/> Harassment/Stalking    | <input type="radio"/> Suicidal thoughts           |
| <input type="radio"/> Homicidal thoughts     | <input type="radio"/> Trauma                      |
| <input type="radio"/> Irritability/Anger     | <input type="radio"/> Other, please specify below |

If you have more than one concern, which causes you the most distress?

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

- |   |   |
|---|---|
| <input type="radio"/> Group psychotherapy                 | <input type="radio"/> Partial hospitalization (Psych Rehab) |
| <input type="radio"/> Individual outpatient psychotherapy | <input type="radio"/> Residential care (CRR, LTSR)          |
| <input type="radio"/> Psychiatric care                    | <input type="radio"/> Substance abuse treatment             |
| <input type="radio"/> Pastoral counseling                 | <input type="radio"/> Other _____                           |

**Have you received psychological treatment in the past?** Yes No

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

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**Have completed an assessment in the past?** Yes No

If yes, at what age and what type of assessment?

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**Have you ever been hospitalized for psychological problems?** Yes No

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

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

- Never
- Once a month
- Once a week

2-3 times a week

4 or more times a week

**Number of drinks per occasion?**

- 1 or 2

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

**Have you ever used marijuana?**                      Yes      No

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

- None
- 1-2 times
- 3-5 times
- 6-9 times
- 10 or more times

**Are you currently or have you ever used any illicit substances or abused any prescription medications or household substances?**      Yes      No

If yes, please specify

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## **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](http://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](http://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.

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**Print Client’s Name**

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**Client’s Date of Birth**

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**Client Signature (if age 13 or older)**

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**Date**

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Print Parent/Guardian/Authorized Adult’s Name

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Relation to Client

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Parent/Guardian/Authorized Adult Signature

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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.

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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 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](mailto: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 ( I R B ) 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.

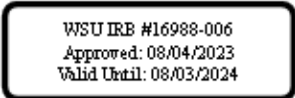
**Statement of Consent**

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.

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Signature of Person Obtaining Consent

---

Date

**DO NOT ALTER OR DELETE ANY PART OF THE ADDENDUM**

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

<b>Principal Investigator:</b> Walter D. Scott	
<b>Study Title:</b> WSU <b>Psychology Clinic</b> <b>Research Database</b>	

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.

**DO NOT ALTER OR DELETE ANY PART OF THE ADDENDUM**

**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.

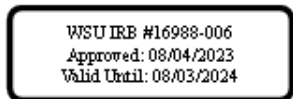
I agree to the use, creation, and sharing of my health information for purposes of this research study

\_\_\_\_\_  
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



**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  
o **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**

**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.

Assessments	Annual Income		
	\$ 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: \_\_\_\_\_