Center for Behavioral Health
UNIVERSITY OF MISSOURI – ST. LOUIS

INFORMED CONSENT
PSYCHOLOGICAL EVALUATIONS

Client Name: _____

Please Read the Following Carefully before Signing

UMSL – Center for Behavioral Health (CBH) is a clinic associated with the doctoral training program in Clinical Psychology at UM-St. Louis. In most cases, clients will be seen by doctoral level licensed psychologists or psychological residents, psychology interns, or doctoral students in Clinical Psychology who will be supervised by licensed psychologists on the CBH staff (referred to as "providers").

1. **Maintenance of confidential case file.** This file will contain identifying data, dates of services, types of services, test results, and an evaluation report. CBH will protect the privacy and confidentiality of your records consistent with the CBH Notice of Privacy Practices. You may request a copy of the Notice of Privacy Practices at any time. The Notice of Privacy Practices describes how your information may be used or disclosed. Your information may be accessed, used, or disclosed for treatment or payment activities, for health care operations, and in other circumstances specified in the Notice of Privacy Practices. There are specific circumstances when we are legally required to give confidential information to a third party. This occurs if we believe a child or a vulnerable adult is being abused or if there is a substantial risk of imminent serious harm to you or someone else. In case of an emergency, confidential information may be shared with a third party on a need-to-know basis without your prior consent. If you have questions or concerns about confidentiality, please discuss them with CBH before beginning your evaluation.

2. **Consultation.** Consultations with CBH staff may be conducted as necessary. Information shared in consultations and supervision is treated confidentially.

3. **Participation**. Your participation is voluntary. You have the right to decline to participate and to stop the evaluation process at any time.

4. **Cancellation Policy**. There is a 24-hour cancellation policy. Please make every effort to cancel all sessions 24 hours in advance. We reserve the right to terminate evaluation services due to repeated late cancellations or failed appointments.

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5. [2] **Cost.**

a) CBH will file for direct payment from the appropriate third-party payer (e.g. grant funders, private foundation, or insurance payers) for payment of the fee for the evaluation, including test scoring, interpretation, report writing, test feedback and case management.
b) A handling and copying fee may be charged for additional copies of assessment reports.

6. **Questions or Complaints About Services.** Questions or concerns that you have about the services you or your child received should be discussed with your provider. If after discussing the issues with your provider you still are not satisfied, please call your provider's supervisor or the Director of CBH or file a written complaint in the clinic. Complaint forms are available in the CBH office. The complaint will be reviewed by the Director of CBH, who will respond directly to you and attempt to resolve the difficulty.

7. **Participation in Telehealth Services.** The Undersigned, an individual over the age of seventeen (17) years, or the parent or legal guardian of a minor, agrees to participate in telehealth services if requested as follows:

a) Telehealth services will be conducted in a confidential and secure manner.
b) These services may be offered via video-conferencing technology, such as a secure version of the Zoom platform that is compliant with applicable health care privacy laws and regulations.
c) My health care provider has determined that telehealth is an appropriate medium to provide these services. However, I understand that my health care provider may at some point determine that telehealth is no longer appropriate for me and may only agree to sessions in-person if possible.
d) I understand that there are certain risks and benefits to telehealth services. Risks include interruptions in service, technical difficulties, and possible breach of privacy should I participate in these services in a location that is not private.
e) I understand that it is important for me to be in a quiet, private space that is free of distractions during the session.
f) If the session is interrupted for any reason, such as the technological connection fails, and I am not having an emergency, I will disconnect from the session and my health care provider will re-contact me as soon as possible.
g) At any time, in the event of an emergency, please call 911 or go to the nearest emergency room.

By Signing This Consent, I Certify:

- I have read or had this Consent read to me and my questions about this Consent or telehealth services have been answered to my satisfaction.
- I acknowledge and agree that this Consent may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature,

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electronically scanned and transmitted versions of an original signature, or typed signature below as follows: /s/ (Signature).

- I understand that this Consent is intended as a supplement to any other informed consent that I have signed at the outset of my clinical work with my health care provider and it does not amend any of the terms of that consent.
- I understand that I am financially responsible for all charges for services rendered to me at CBH and I agree to provide payment for these services.
- I understand and agree to the nature and purpose of this evaluation, and consent to the psychological evaluation. If signing as a parent or legal guardian on behalf of a client, by signing below I affirm that I have legal authority to make medical decisions and sign authorizations on their behalf.

Patient Name and Date of Birth: _____

_____ _____

Patient/ Parent/ Guardian Signature Date

Please indicate relationship to patient:

☐ Self

☐ Parent

☐ Legal Guardian

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