UNIVERSITY OF TENNESSEE PSYCHOLOGICAL CLINIC
Confidential Information – Youth

(please print)

Name_____ SS# _____ Date _____
First middle or maiden last

Age: _____ Date of Birth: _____ Sex: _____Preferred Contact: _____

Home Address _____
Street City State Zip

Mother's Name _____ Legal custody of Youth? _____
First middle or maiden Last

Mother's Address_____
Street City State Zip

Mother's Occupation _____ Employer _____

Mother's home phone _____ Mother's work phone _____

Father's Name _____ Legal custody of Youth? _____

Father's Address _____
Street City State Zip

Father's Occupation _____ Employer _____

Father's home phone _____ Father's work phone _____

Name of other legal guardian _____ Work Phone _____

Guardian's Address _____ Home Phone _____
Street City State Zip

Guardian's relationship to youth _____

Total Household (Annual) Income: _____

Youth's Immediate Family (for younger children, include all persons other than parents living with the child)

Name	Relationship	Age	Occupation/Grade	Residence

Youth's school_____ Teacher _____

Grade_____ Special classes _____

Please complete the following medical conditions:

Family physician:_____ Date of youth's last medical examination_____

If youth is currently under care of a physician for a continuing Health Problem, please five the physician's name and phone number:

_____

Does youth take regular medications? If so, what medications?

Name of medication	Dose	Frequency

_____

_____

_____

Previous Mental Health Services:

Types of Services	Provider	Dates of Services

_____

_____

_____

_____

Current or expected legal involvement? _____ Yes _____ No If yes, please explain:

_____

_____

Referred by:_____ Relationship _____ _____

Non- Parent to notify in case of emergency:_____ Relationship_____

Address:_____ Phone:_____

Religious affiliation:_____

List youth leisure interests _____

What do you consider to be youth's strengths?

Briefly describe the problems and reasons that brought you here:

Briefly list goals of youth's treatment here; that is, what you would like to achieve and/or see happen by coming here for care:

Application for Services
Financial Agreement

Client's name _____ Date of Birth _____ SSN _____

It has been explained to me that the fee for services for the above-named client will be:

$_____ per individual psychotherapy session (circle one: child adult).

$_____ per (circle one: group family marital couple) psychotherapy session.

$_____ University-Level **Psychoeducational Evaluation**.

$_____ Vocational Rehabilitation Evaluation.

$_____ Disability Determination, Social Security

$_____ Court Ordered Psychological Evaluation

$_____ Court Ordered Custody Evaluation per adult + $__**50**__ **per hour per child**.

$_____Court Ordered Psycho Sexual Evaluation

$ _____ Fitness for Duty/Return to Work Evaluation.

$ _____ Fitness for Parenting (Permanency Plan).

$ _____ Pre-Marital Counseling (DSM-IV: V71.09)

$ _____ Pre-Surgical Evaluation

$ _____ All other evaluations: $25 per hour of direct contact.

I accept responsibility for payment of charges for services to the above-named client. I agree to make full payment of all charges for which I am responsible on the day services are rendered, unless other arrangements have been made with the psychotherapist, who has detailed these other arrangements as follows: _____. **I understand and agree that I may be charged for missed appointments not cancelled 24 hours in advance.** I further agree to pay all attorney's fees and other reasonable collection costs and charges necessary for the collection of any fee(s) for services not paid when due.

I understand, and agree that, in the event of delinquent payment by the financially responsible party, the University of Tennessee Psychological Clinic may use a collection agency and/or the courts to pursue payment. I further understand and agree that such action could require that, without my further consent, the parties involved, reveals the diagnosis of the named client, and describes the dates and nature of charges incurred, as well as other information that may be pertinent to the collection of fees. I fully understand and freely consent to the release of any and all such client information as is necessary for the collection of fees for services to the above named client. This consent shall remain in effect until all fees for all services have been fully recovered.

_____ _____

Signature of adult client or parent/legal guardian of client less than 18 years of age

Date

Policies & Procedures

The University of Tennessee-Knoxville Psychological Clinic

The UT Psychological Clinic is a training and research facility operated by the Dept of Psychology. The Clinic has been serving citizens of the Knoxville community as well as students and employees of the University for more than fifty years. Adults and children alike are seen at the Clinic for services ranging from psychological and psychoeducational evaluations to a variety of psychotherapeutic activities including but not limited to individual psychotherapy, marital/family therapy, and other applied clinical services. Our services are provided by graduate students in the Clinical Psychology Doctoral Training program, under the direction supervision of licensed Clinical Psychologists. Administrative responsibility for the operation of the Clinic and for the services provided rests with the Director of Clinical Training and the Director of the Psychological Clinic.

Appointments:

The Clinic is open from 8:00 A.M. until 8:00 P.M. Monday through Thursday and 8:00 A.M. until 4:30 P.M. on Friday. Patients are seen by appointment only. There are no walk-in or emergency appointments available for new patients; emergency services are available only for already existing patients of the Clinic. New prospective patients needing emergency appointments are referred to the UT Medical Center, 1929 Alcoa Highway, Knoxville, TN 37920 (544-9401).

Emergencies and Telephone Calls:

While you will be seen at the reserved time agreed upon by you and the Clinic staff there may arise occasions when you need to talk to your therapist between appointments. Should you call between appointments during regular Clinic office hours, your therapist will return your call as promptly as possible. If you call the Clinic after we are closed for routine matters, leave your message on our answering machine and we will respond to your call the next working day. In the event of an emergency after hours, call the Clinic phone number and you will be given the emergency number to call which is monitored on a twenty-four (24) hour a day basis.

Fees and Payments:

Payment is due on the day the service is rendered unless you have made prior arrangements which we have agreed to in writing. Fees for interventions are set in accordance with your household income. The initial fee for the first visit is $55.00. Fees for specialized assessment activities such as court-ordered custody evaluations or Pellissippi Psychoeducational Evaluations vary according to the type of assessment desired and you will be told the exact fee for your requested assessment before that actual assessment begins. Your fee will be agreed upon at the time of the first visit and a separate fee agreement will be signed by you, indicating your acceptance of your assigned fee. At this time, the Clinic does not file or receive reimbursement from insurance companies.

Confidentiality, Privileged Communications, and HIPAA Requirements:

The Psychology Licensing Law provides extremely strong privileged communication protections for conversations between your Psychologist and you in the context of your established professional relationship. We strive to maintain the privacy of you confidential communications between you and your therapist. There is a difference between privileged conversation and documentation in your mental health records. Records are kept documenting your care here as required by law, professional standards, and the Health Information Portability and Accountability Act (HIPAA). Your therapist will give to you a separate document of your Notification of Patients Rights as required by HIPAA. The new HIPAA law effective 4/14/03 very clearly defines what kind of information is and is not to be included in your designated mental health records. For example, HIPAA declared "psychotherapy notes" are not to be part of your designated mental health record with our psychotherapy notes defined as "notes recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and that are separated from the rest of the individual's medical record."

Because we are a training and research Clinic, our operations are governed by confidentiality, privileged communication, HIPAA requirements and some additional special provisions due to our University research and training functions (i.e., IRB approval of all research performed at the Clinic; the use of videotape equipment). Hence, at the UT Psychological Clinic, the following are considered components of your "designated mental health record" which we strive to keep in strictest confidence: all identifying paperwork you completed when you first start your care here, all billing information, a summary of your first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, interim summaries of your care here, any summary results of any psychological testing performed by us, any information you provide us, as part of an approved research project you've consented to participate in which is going to be kept in your Clinic chart, any letter we've written that you've authorized us to send on your behalf and any information received by us from a third party. Your "designated mental health record" does NOT include our psychotherapy notes of sessions we conduct, the actual raw data or questions of any psychological tests given by us, videotapes of your sessions here, notes of conversations between your therapist and the supervisor of the case unless such notes are specifically included in your progress notes, and any work products for the assessment courses offered by the doctoral training program in clinical psychology. We videotape sessions here at the Clinic to help with the training of our doctoral students in our Clinical Psychology Training program. Videotapes are watched between your therapist and our staff for supervisory and training purposes only with sessions erased once the educational purpose has been completed. Similarly, our doctoral students review the results of actual psychological testing performed at our Clinic in their required courses and practicum in psychological testing. Identifying information is removed when testing is used in these educational settings so that like our use of videotapes, protected health information remains securely confidential.

Tennessee law requires authorization and consent for treatment, payment and healthcare operations and we will secure this consent to care before we begin working with you. Additionally, if you ever want us to send any of your protected health information to anyone outside our office, you will always first sign a specific authorization to release information to this outside party. Should we, in conjunction with you, ever decide to send our psychotherapy notes to an outside party, we will first secure an additional authorization from you to do so. Marital therapy and couples therapy present special conditions given the constraints of privileged communication laws however, we will always secure a release of information to the non-identified patient member of the couple being seen here for either marital or couple therapy.

There are some exceptions to confidentiality and privilege rights which might result in use and disclosure without your consent and authorization such as the reporting requirements for child abuse, suspected sexual abuse of a child, adult and domestic abuse, health oversight activities (licensing board), judicial or administrative proceedings (i.e., you have no privilege communication or confidentiality in court-ordered evaluations or if you use your mental condition as a part of a lawsuit you are pursuing), Workers Compensation claims, or a clear and imminent serious physical injury risk to yourself and/or to others. Additionally, because we are a training and research facility there are times when we may disclose your protected health information on research projects already approved by the University of Tennessee's IRB and projects you consented to participate in because it may not be practical to contact you. In all of the research projects conducted at the Clinic, careful measures are taken to protect your privacy and the risks to you are judged to be minimal and reasonable in relation to the anticipated benefits of the research.

Participation in Research Activities:

In addition to traditional evaluation and psychotherapy services, patients at the Clinic may be asked to participate in the various research projects conducted at the Clinic. **ALL** research projects at the Clinic are first reviewed and approved by the University of Tennessee- Knoxville's Institutional Review Board (IRB) prior to the start of any research activity conducted at the Clinic. Such a requirement helps promote privacy of protected health information as well as protecting the rights and welfare of the prospective research participant. All participation in research projects at the UT Clinic is strictly voluntary and not a condition for receiving services. Research data is typically coded by assigning your information a private code number linked to a master key that is kept in a separate location from your designated mental health record. If you complete psychological testing or other questionnaires as part of the research project, this information may be kept in your mental health record. Sometimes we will

conduct IRB-approved archival research on documents in your designated mental health record for which you agreed to participate although it may not be possible for us to inform you that we are beginning a new study on these archival documents. Any IRB-approved research data collected at the Clinic that is not kept in your designated mental health record will be kept in your research record in accordance with the specifications of the IRB-approved research project. Individual participants in any research project conducted at the Clinic will not be identified in any presentations or publications based on the results of the research study.

Under federal privacy regulations, you have the right to determine who has access to your protected health information (PHI) in your designated mental health record. PHI collected in our research studies may include demographic information, psychological testing, questionnaires, rating scales or other data that will be specifically identified in the consent form you will sign prior to the start of the research project. By signing this consent form, you are authorizing the research team at the University of Tennessee-Knoxville to have access to your protected health information conducted in the study. In addition, your PHI may be shared with other persons involved in the conduct of this research such as the principal faculty member and/or dissertation committee responsible for overseeing of the research project. The IRB at the University of Tennessee-Knoxville may review your PHI as a part of its responsibility to protect the rights and welfare of research subjects. Your PHI will not be used or disclosed to any other person or entity, except as required by law, or for authorized oversight of the research project by other regulatory agencies, or for other research which the use and disclosure of your PHI has been approved by the IRB. Your PHI will be used only for the research purposes described in the specified consent form you sign. Your PHI will be used until the study is completed as well as kept for potential future archival research purposes.

You may cancel your participation in research authorization in writing at any time by contacting the principal investigator of the research project or by contacting the Director of the UT Psychological Clinic. If you cancel the authorization, continued use of your PHI is permitted if it was obtained before the cancellation and its use is necessary in completing the research. However, PHI collected after your cancellation may not be used in the study. If you refuse to provide this authorization, you will not be able to participate in the research study. If your cancel the authorization, you will be withdrawn from the study. Federal regulations allow you to obtain access to you PHI collected or used in the study to the extent deemed permissible by your therapist. However, in order to complete the research, your access to this PHI may be temporarily suspended while the research is in progress (i.e., if a component of the study involves keeping certain data secret from the research subject until later in the study). When the study is completed, your right to access the information will be reinstated.

Your Informed Consent to Care:

In signing our consent to care, you acknowledge understanding all of the aforementioned policies and procedures of the Clinic, including the special training and research provisions associated with our Clinic. Additionally, psychological evaluation and care, like other things in life, offer no absolute guarantee of success and there are limitations to any form of care offered a patient. Any questions about the nature of psychotherapy, its risks and benefits, the time period required or alternative forms of care should be asked of your therapist. After we have met to discuss your concerns with you, the therapist working with you will construct an individualized treatment plan for what problems we are going to try to solve with you and how. Your signature below acknowledges your informed consent to care and your understanding and agreement to these policies and procedures as stated above.

_____

Signature of adult patient or parent/legal guardian of
Patient less than 18 years old

_____

Date