Community Mental Health Services
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ASSESSMENT SERVICES AGREEMENT

Welcome to West Chester University (WCU) Community Mental Health Services (Clinic). This agreement contains important information about 1) our professional services and special conditions related to being a training clinic, 2) summary information about the Health Insurance Portability and Accountability Act (HIPAA) and confidentiality, and 3) our clinic business practices. It is important that you read it carefully and ask any questions you might have. You will be given a copy to take home and are welcome to call later with questions as well. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of protected health information (PHI) for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature today acknowledging that we have provided you with this information. In addition, when you sign this document, it will represent an agreement between us; you may revoke this agreement in writing at any time. That revocation will be binding unless a) the clinic has already taken action in reliance on it, b) has legal obligations imposed on it by a court of jurisdiction, or c) if you have not satisfied financial obligations you have incurred.

PURPOSE AND MISSION

The clinic is a training site associated with the WCU doctoral program in clinical psychology. Assessments are conducted by clinical psychology graduate students who are supervised by clinical staff and faculty. Your evaluator will provide you with the name of his or her supervisor. Your assessment will be observed and/or recorded (audio/video) for the purpose of training. The evaluator, supervisor and small team of clinical graduate students may view the tapes and discuss your case as part of their training. All such tapes will be erased as soon as possible after services have been rendered. The only exception is if you otherwise grant permission to a faculty supervisor by a separate written consent.

In addition to training, we also have a service mission. The clinic is dedicated to providing quality psychological and academic assessments to the greater West Chester community at low cost. Unfortunately, we are not able to provide all services and may have a waiting list depending upon the availability of clinicians. If we cannot assist you, we will attempt to provide you with several referrals.

ASSESSMENT SERVICES

Providing a thorough assessment/evaluation will include direct, face-to-face contact, interviewing, testing and/or completing questionnaires. It may also include time required for the reading of records, consultations with other psychologists/professionals, scoring of tests, interpreting results, and any other activities to support these services. In order for the evaluation to provide valid results, it is important that you help as much as you can by providing full answers and making an honest effort. If you have questions or concerns about the assessment or any of the procedures, the evaluator is available to discuss them.

CONTACTING US AND EMERGENCY CARE

The clinic hours are limited to _____ during the week and may be shorter in the summer. The clinic provides full time administrative phone coverage during working hours, but you may not be able to reach your evaluator who may be in class or seeing other patients. Your evaluator will make every effort to return your call as soon as possible. If you are difficult to reach, please provide us with times you might be available. If you cannot reach us and are having an emergency you should contact your physician or other community resources directly; we will provide you with a list of community resources.

LIMITS TO CONFIDENTIALITY

The law protects the privacy of all communications between a client and a mental health provider. In most situations, we can only release information about your assessment to others if you sign a written Authorization. Below are situations that require only written, advance consent, which you provide when you sign this agreement:

- Clinical information about your case may be shared fully within the WCU clinic by the students enrolled in clinic practicum and staff/faculty for educational and evaluation purposes. If clinical staff present case information at professional conferences, the information will be disguised such that it is impossible to link the information to you or your family.
- We employ administrative staff who have access to some of your protected information for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All staff members have been given privacy training and have agreed not to release any information outside of the clinic.
- On occasion, the clinic may find it helpful to consult with another health or mental health professional. During such a consultation, every effort is made to avoid revealing the identity of the client. The other professional is legally bound to keep the information confidential. All consultations are noted in the client's clinic record.
- If a client seriously threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided to you, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a client files a complaint or lawsuit against the clinic, we may disclose relevant information regarding that client as part of our defense.
- If we are evaluating a client who files a worker's compensation claim, we may, upon appropriate request, be required to provide otherwise confidential information to the employer.

There are some situations in which we are legally obligated to take actions to protect others from harm and which may require us to reveal some information about a your treatment:

- If we have reason to believe that a child is the victim of abuse or neglect, the law requires that we file a report with the Pennsylvania Department of Child Welfare (i.e. ChildLine). Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we are required to report this to the Pennsylvania Department of Aging. Once such a report is filed, we may be required to provide additional information.
- If we believe that a client presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, we are required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information (PHI) about you in your Clinical Record for six (6) years. Except in unusual circumstances that involve danger to yourself and/or others, or where information has been supplied to us confidentially by others, or the record makes reference to another person (unless such other person is a health care provider) and we believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. We do not provide copies of testing protocols or test scores directly to clients; however we will provide them to another professional if requested. In most circumstances, we are allowed to charge a fee to cover any expenses incurred providing this information. If we refuse your request for access to your records, you have a right of review (except for information that has been supplied to us confidentially by others).

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

RESEARCH

The clinic also serves as a site for clinical research conducted by doctoral students and faculty. You may be approached for participation in research studies that have received prior approval from the West Chester University Institutional Review Board. Prior to any research participation, a separate informed consent fully explaining the study must be provided, and you can choose either to participate or not to participate. You will never be penalized for choosing not to participate in research.

BILLING AND PAYMENTS

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation to avoid the $10.00 cancellation charge. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose otherwise confidential information. In most collection situations, the only information we release is the client name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

The clinic is considered an out of network provider for all insurance policies. If you wish to apply for payment under a health insurance policy, the clinic will provide you with a claim form that you can send to your insurance company for reimbursement. Most insurance does not cover academic assessments. It is very important that you understand what your insurance covers and does not cover. Sometimes prior authorization is required. If necessary, call your plan administrator to have your questions answered. Ultimately, you (not your insurance company) are responsible for full payment of the clinic fees.

You should also be aware that health insurance companies require that the clinic provide them information relevant to the services provided. This often includes a diagnosis and clinical summary. The clinic will make every effort to release only the minimum information about you that is necessary for the purpose of reimbursement.

CONSENT AND AGREEMENT FOR PSYCHOLOGICAL TESTING AND EVALUATION

I, _____, agree to allow the evaluator named below to perform the following services:

❑ Psychological testing, assessment, or evaluation
❑ Report writing
❑ Consultation with school or other health care professionals
❑ Other (describe): _____

This agreement concerns ❑ myself or ❑ _____

I understand that these services may include direct, face-to-face contact, interviewing, testing and/or completing questionnaires. They may also include the evaluator's time required for the reading of records, consultations with other psychologists/ professionals, scoring of tests, interpreting the results, and any other activities to support these services. If I have questions or concerns about this assessment, the evaluator agrees to be available to discuss these after completion of the testing and interviews.

I understand that the fee for these services will be $ _____, and that this is payable in two parts: a deposit of $ _____ payable on the first day of testing, and a second payment of the balance due on the completion and delivery of any report. I understand that I am fully responsible for payment for these services.

I understand that this evaluation is to be done for the purpose(s) of: _____
_____

I also understand and the evaluator agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations and with the applicable state and federal laws.

2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests' manuals and/or peer reviewed sources, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.

3. Tests and test results will be kept in a secure place to maintain their confidentiality.

4. The report of the findings of this assessment will be sent to _____
_____

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

I have read and agree to the above professional services and special conditions related to being a training clinic, summary information about HIPAA and confidentiality, and WCU's clinic business practices.

_____ _____
Signature of client Date

_____ _____

Signature of parent/guardian Date

I, the evaluator, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Evaluator Date

_____

Name of Supervising Psychologist

_____ _____

Signature of Supervising Psychologist Date

❑ Copy accepted by client