Welcome to the Counseling and School Psychology Clinic (CSPC). Our mission is to provide quality services that improve the educational, social, emotional, and behavioral functioning for the clients we serve. Clinicians are counseling and school psychology graduate students who are supervised by licensed psychologists. This document contains important information about your rights and responsibilities and our clinic business practices.

**CONSENT TO THERAPY AND CONFIDENTIALITY**

In signing this document, I provide my voluntary consent to participate in treatment for myself. I understand that I may refuse and/or terminate services for myself at any point, without adverse repercussions between this agency and myself.

I also understand that the CSPC will maintain protected health information records relevant to therapy, as well as information obtained through consultation with other professionals. Records will be kept in accordance with professional, legal, and ethical guidelines for providers by the American Psychological Association (APA), the American Counseling Association (ACA), and will be kept separate from any other university records. I understand that these records are restricted to the internal use of the CSPC and their confidentiality will be strictly maintained at all times. I also understand that the CSPC will follow stringent state regulations, regarding the maintenance of client records. Specifically, full records will be kept for 7 years after the last date of service for adults or until 3 years after a minor reaches the age of majority, whichever is later.

I understand that the CSPC has clinic administrative staff and students who manage clinic operations (e.g., scheduling, filing, billing), and that these individuals have been bonded to uphold the state and federal guidelines with regards to standards of care and maintenance of confidentiality.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), the CSPC will release the written and/or verbal information regarding my intake or treatment sessions only upon receipt of my written consent and only to those specified by myself, except in unusual circumstances. In circumstances where there is risk of danger and/or impending harm to myself or others, abuse or neglect of a child, abuse or neglect of an elderly person, and/or certain legal situations (e.g., a court subpoena of records), the CSPC would be mandated by law to disclose such information for your protection and/or the protection of others. In such situations, my provider will make reasonable attempts to discuss the situation with me and enlist my participation in resolving the matter, if possible. If I have any questions, I understand that I can discuss them freely with my provider.

Additionally, I understand that on occasion, clinic students and/or faculty may find it helpful to consult with other mental health professionals. During such a consultation, I understand that
CONSENT FOR SUPERVISION, OBSERVATION, AND RECORDING OF COUNSELING SESSIONS

To ensure the quality services, students will regularly videotape and/or audiotape sessions, and are assigned to supervisors with whom to consult concerning the progress of counseling. Given that the CSPC is a training clinic for students learning to provide mental health services to clients and families, I understand that the purpose of recordings and/or session observations is to provide students with supervision on the counseling process. I understand that all videotaping and audio recordings, and any identifying information will be kept confidential. In addition, observations of sessions will be made only by designated clinic professionals (e.g., other clinic students within the same training cohort, supervisors). Recordings will be maintained no longer than one academic year.

RESEARCH

I understand that the CSPC may also serve as a site for clinical research, conducted by graduate students and faculty within the department. Clients may be asked to participate in clinical research studies that would help assist in the advancement of clinical care and therapeutic outcomes. These studies have been approved by the Institutional Review Board (IRB). Prior to any participation in research, clients will be asked to complete a separate informed consent fully explaining the study. Declining to participate in research studies will not impact the delivery of clinical services in any way.

I also understand that summative, de-identified client information (e.g., trends, outcomes) may be collected and used to enhance the delivery of services and operations within the clinic.

EMERGENCY CARE AND CRISIS SITUATIONS

I understand that the CSPC is not able to provide emergency services or psychiatric services. Individuals who may be experiencing severe mental illness resulting in the need for substantial clinical care and/or case management, on-going medication adjustments, and/or emergency mental health services may not be appropriate for a training clinic and may require a referral to an outside agency.

CSPC clients who are experiencing a crisis are encouraged to discuss this with their therapist as soon as possible, so that a safety plan can be developed. I understand that my clinician will work with me to establish a plan to help restore normal functioning as soon as possible, should I experience a crisis. I understand that my clinician may seek additional support from their clinical supervisor, and that minimal treatment information may be shared with other professionals whom I interact with, in order to help protect me in the event of a crisis.
I understand that if I should experience an imminent crisis, I will be instructed to contact an emergency number (911) and/or visit the nearest emergency room. Additionally, I understand that the CSPC does not offer a crisis or emergency support phone line.

FEES, BILLING, AND PAYMENT POLICY

The CSPC is pleased to offer flexible, low-cost clinical services to clients and families in the community, as well as to University of Nebraska-Lincoln students, staff, and faculty (please see Fee Agreement for additional information on service costs). I understand that the CSPC does not accept any insurance.

I understand that I will receive a monthly statement for all services rendered during that time frame, for the per-session amount I indicate on my Fee Agreement. Methods of payment for services include cash, check, and credit card. Cash payments must be made in-person. Checks must be made out to the University of Nebraska-Lincoln. The CSPC’s current credit card payment system is web-based and can be accessed through the payment portal on the CSPC website (https://cehs.unl.edu/edpsych/clinic/). I understand that I will receive instructions for accessing my payment portal, along with information about how to submit other forms of payment towards my balance, with each monthly statement.

I understand that if I am unable to pay the full amount towards my balance, I will pay what I can towards the balance. I understand that if my financial circumstances should change or should I experience financial hardship, I will notify my provider and request to reset my fee agreement upon the Clinic Director’s approval.

SUMMARY OF CLIENT RESPONSIBILITIES

As a client of the CSPC, I agree to:

• Keep regular appointments and actively participate in my treatment
• Make a commitment to living and using clinic and community resources to resolve stressors
• Disclose to my therapist if I should ever feel in crisis and/or suicidal, to work with my provider to develop a safety plan, and to give the clinic discretion regarding needed disclosures in a crisis situation
• Come to the clinic free of any influence of alcohol and/or drugs
• Never bring a weapon of any sort into the clinic or on campus
• Ask my therapist questions right away if I feel uncertain about my evaluation, therapeutic process, treatment plan, or any clinic policy

• Pay agreed upon treatment fees

**INFORMED CONSENT**

My signature below indicates that I have read this agreement and agree to its terms. These matters have been explained to me and I fully and freely give consent to receive clinic services. I also understand that I have the right to refuse to sign this consent form. By my signature, I also authorize that a photocopy and/or facsimile (FAX) copy shall have the same effect and authority as the original copy of this document.

___________________________________________
Name of Client (please print)

___________________________________________  __________
Signature of Client                              Date

___________________________________________  __________
Witnessed by                                   Date