UtahStateUniversity

Mind-Body Bridging Clinic

Informed Consent and Consent for Treatment

_____ I understand that I am entitled to free short term therapeutic intervention (Clients requiring a higher frequency of services than resources allow may be referred to an external provider).

_____I understand that I am consenting to enter into a treatment agreement with the I-System Institute's Mind-Body Bridging Clinic..

_____I understand that if I am under the age of 18, parental consent is required to participate in therapeutic services.

_____I understand that if I am under the age of 18, the specific content of therapeutic communications is confidential but my parents/guardians do have a right to receive general information on the progress of treatment.

_____I understand that I will be seen by either a Certified or Licensed Clinical Social Worker or a Master of Social Work Practicum Student (Intern), neither of whom can prescribe medication.

_____I understand that the clinic staff works as a team. This means that my therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes and will be staffed with the licensed supervisor.

_____I understand that treatment which falls beyond our therapists' areas of expertise or outside the scope of services provided may be referred to an outside treatment provider (e.g. treatment for disorders of such severity that we cannot provide adequate care: treatment for an eating disorder that requires closely coordinated medical, nutritional, psychiatric, and psychological care).

_____If long term treatment is desired or necessary, I understand that I will receive assistance in locating a treatment provider and an appropriate referral will be made.

_____I understand that appointments are typically scheduled in 45 minute increments in order to allow the therapist time to complete case documentation.

_____I understand that if I miss ("no show") 3 sessions in a row, clinic services will be terminated and my slot will be allocated to another client.

_____I understand that my appointment will be considered a "no show" if I am more than 15 minutes late without notifying the office. I further understand that my appointment may still end at the originally allotted time.

_____I understand that if my behavior creates a hostile working environment for the counseling staff and/or other individuals in the office, treatment may be terminated.

_____I understand that the counseling office does not have on-call hours, and if I am experiencing a mental health emergency, I need to call 911 immediately.

_____I understand that the counseling office does not have a receptionist and does not send out appointment reminders unless the appointment is scheduled using the online scheduling system.

_____I understand that counseling records are stored in locked files and/or electronically on a secure server that is only accessible by our staff. Upon request, I may review my counseling records.

_____I understand that if I am unhappy with what is happening in therapy, I can talk with my clinician, the clinic director about my concerns. I can expect them to take such criticism seriously, and to respond with care and respect.

_____I understand that email communication is not a confidential form of communication and my therapist cannot guarantee confidentiality in communicating through that format.

_____I understand that my therapist is unable to ensure complete confidentiality on a telehealth call, and I am responsible for ensuring my end of the call is confidential.

_____I understand that due to state licensing requirements, telehealth services cannot be provided across state lines.

_____ I understand that my records will be released only with my written consent, except as may be specifically required by law (i.e. if reports are made of the abuse of a child, elderly or disabled person; as required by duty to warn laws; if protection is needed to ensure safety from immediate danger to self or others; if you are a minor whose parents have access to your records; in the case of a court order being made by a judge; in response to a lawfully issued subpoena; if needed to comply with a licensing investigation; or where otherwise legally required).

_____ I understand that if my therapist has real concern that I am a risk to myself or others, the local mental health authority or emergency services would be contacted to make the determination as to whether hospitalization is required.

_____ I understand that if I am currently involved with the court system (i.e. DCFS, AP&P, etc); the court requires a large time commitment from the therapist which is beyond the scope of the services offered and a referral will be made to a more appropriate therapeutic agency.

_____ I understand that this office does not provide court ordered or forensically oriented treatment (e.g. intensive outpatient treatment for substance abuse, treatment for criminal behavior, etc.).

_____ I understand that this office does not provide full psychological assessment services (e.g. neuropsychological assessments, forensically oriented assessments for DCFS/Vocational Rehab, etc.).

_____ I understand that my therapist may have pandemic precautions and if I am unable to abide by those precautions, my therapist may need to schedule my appointment virtually.

_____ I understand that my therapist is not qualified or registered with the Utah Department of Health to recommend medical cannabis as a treatment.

_____ I understand that documentation for emotional support animals is outside the scope of practice of student counseling services.

_____I understand that I may periodically receive client satisfaction questionnaires in the course of treatment.

_____ I consent to my information being used for research and program evaluation purposes. The information will be used only for research and program evaluation purposes and in ways that will not reveal who you are. Any personal information that could identify you will be removed or changed before results are made public. You will not be identified in any publication from research or program evaluation that uses your information.

_____ I understand that this clinic does NOT provide mental health diagnostic services.

By initializing the above items and by signing this form, I acknowledge my understanding of each above listed item and verify that I have had an opportunity to ask questions and discuss these items with MBB Clinic staff.

_____ _____

Client Signature Date