THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

DEPARTMENT OF PSYCHOLOGY

Client Contract

I, _____, do hereby declare that I agree to participate in treatment and/or psychological evaluation at the *Meltzer Psychological Services Center*. The evaluation will consist of a clinical interview and psychological assessment procedures. Results of a psychological evaluation will be given to me, or in the case of minors, to the parent(s) or legal guardian.

If my child, _____, is participating in treatment or psychological evaluation, I hereby declare that I am the legal guardian and I allow him/her to receive services.

Additionally, I understand that:

- Any information that is disclosed during the course of my treatment is subject to federal and local confidentiality laws and regulations, including the D.C. Mental Health Information Act.
- Federal and local laws require that any information about suspected abuse or neglect of children, elders, or the mentally or physically handicapped, or information about the possibility of a patient posing a threat to himself or others, will be reported to the appropriate state or local authorities.
- I understand that the provider of services is a student and information about myself and/or my child will be discussed with his/her immediate supervisor for the purposes of training.
- I understand that sessions will be audio taped, videotaped or observed for the purposes of student training.
- I understand that the Meltzer Center is a training facility within an academic department and that my clinical data and/or health information may be used in research studies or publications. I further understand that any identifying information will be removed prior to the inclusion of my clinical data and/or health information in any such research report or publication.
- I understand that The Meltzer Center does not provide 24 hour service. In case of an emergency I will call 911 or proceed to the nearest emergency room.
- In some cases clients may need services that the Meltzer Center cannot provide. In these situations clients will be referred to a more appropriate setting.
- Furthermore, I certify that I have received both a verbal and written explanation of my rights and responsibilities as a patient.

Clients' Rights and Responsibilities

As a client at the *Meltzer Center* you have the right:

- To be treated with dignity and respect.
- To receive the most appropriate treatment regardless of age, gender, race, religion, sexual orientation, national origin, or method of payment.
- To know what fees will be charged for services in advance of services and to be informed of fees due at each session.
- To privacy and confidentiality concerning your treatment and your treatment record.
- To be free from physical, mental or sexual harassment.

- To notify your primary provider if you are not satisfied with your care. If your concerns are not addressed to your satisfaction, you may contact the Clinic Director. If your concerns remain unresolved, contact the Chairman of the Psychology Department.
- To have your concerns addressed in a timely manner.
- To have all assessment procedures explained in an understandable manner.
- To participate in the development of a comprehensive Individualized Treatment Plan.
- To obtain information regarding your Individualized Treatment Plan at any time and to be notified of any changes as soon as possible.

As a client of the *Meltzer Center* you have a responsibility:

- To keep your assessment or therapy appointments. If you cancel more than two appointments, your name will be placed back on the waitlist. If you miss more than two assessment appointments, your assessment will be terminated and you will be responsible for the full fee.
- To make payment for services: Clients agree to the pay the fee established with the clinical assistant, fee reduction requests should be settled before the first appointment. Payment for sessions is due at the time of the appointment. Fees for psychological assessment should be paid in full at the first appointment. Fees are subject to change.
- To keep your therapy appointment or notify your primary provider of any changes in scheduling within 24-hours or you will be charged for the therapy session.
- To collaborate in the development of your Individualized Treatment Plan.
- To work towards the achievement of your treatment goals.
- To be honest with your provider and share any information which might impact on your treatment.
- To pay your fees in a timely manner and/or discuss with your provider any related financial difficulties.
- To notify your provider if you are dissatisfied with your treatment
- To notify your provider if you wish to terminate treatment.

Authorization for Recording or Observation of Psychological Services

The Meltzer Center is committed to providing quality treatment to our clients, we well as supervision and training of our clinical staff. Quality of treatment can be significantly enhanced by the use of recording and/or observation of therapy and testing sessions.

Supervision: Audio or video recording testing or therapy sessions for supervisory review enhances the quality of treatment and the learning process. Live observation through a one-way mirror by supervisors and trainees also enhances training.

Training and Teaching: Reviewing specific portions of a videotaped session helps in teaching and demonstrating specific therapeutic techniques. Prior to using a video clip, your approval would be sought and you would be able to specify which portion of the tape may be shown.

I _____ give authorization for the Center staff to use audio and video recordings of testing and/or therapy sessions for the following purposes (check all that apply):

Supervision _____
Training and Teaching _____

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I give authorization for the Center staff to observe testing and/or therapy sessions through a one-way mirror for the following purposes (check all that apply):

Supervision _____
Training and Teaching _____

All identifying information will be removed prior to using the materials for the above purposes. All audio and video recordings will be identified by a client number to conceal and protect the identity of you/your child and to ensure confidentiality. Further, all recordings will be stores in a locked cabinet when not in use. After use, any tapes reviewed in supervision will be completely destroyed, unless you give permission for approved portions of tapes to be used for teaching purposes.

By signing this I agree that I have read the above consent form and have had the opportunity to ask questions that have been answered to my satisfaction and in a manner that I understand.

_____ _____
Client Signature Date

_____ _____
Provider Signature Date

_____
Provider Name