THE MELTZER CENTER
PSYCHOLOGICAL AND COMMUNITY-BASED SERVICES

Client Contract

I, ________________________________, do hereby declare that I agree to participate in treatment
and/or psychological evaluation at The Meltzer 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 him/herself 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 recorded and/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.

Client 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 Director of the Clinical Program.
- 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 consecutive 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 in a timely manner and/or discuss with your provider any related financial difficulties: Clients agree to pay the fee established. 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 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, as 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:** 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 and treatment.

**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 recording may be shown.

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

Supervision ____
Training and Teaching ____

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):

Revised 6/5/2015
Supervision _____
Training and Teaching _____

All identifying information will be removed prior to using the materials for the above purposes. All recordings will be identified by a client number to conceal and protect the identity of you/your child and to ensure confidentiality. After use, any recordings reviewed in supervision will be completely destroyed, unless you give permission for approved portions of recordings 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

Revised 6/5/2015