CONSENT FOR TREATMENT AND PAYMENT, AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Welcome to the Anxiety & Stress Clinic (ASC) at the University of Texas at Austin (the “Clinic”). This consent and acknowledgement document contains important information about our professional services and business practices, special conditions related to being a graduate student training clinic, outcome assessment system, and information about the Health Insurance Portability and Accountability Act (HIPAA). We encourage you to read it carefully and to ask any questions you may have. We will give you a copy to take home.

SUPERVISION AND TRAINING: Clinic services are primarily provided by graduate student therapists and postdoctoral fellows, who are under the direct supervision of a Licensed Psychologist. The supervisor’s name and contact information is listed below. Some services are also provided directly by Licensed Psychologists. It is standard procedure for sessions to be videotaped for supervision and educational purposes. Student therapists are supervised either on an individual basis or in a student therapist group. One of the main purposes of supervision and training is to assist our therapists in providing the best possible services to their clients. Clients will be asked to complete various clinical assessment measures during treatment.

FEES AND INSURANCE REIMBURSEMENT: We are committed to providing high quality treatment services. Since the Clinic's primary purpose is clinical training, our fees are modest and adjustable. Clients are expected to pay for each therapy session at the time of the appointment. Many insurance companies will reimburse for services provided here. Although the Clinic will not file the claim for you, we will provide you with a comprehensive statement that you can send to your insurance company for reimbursement. We cannot ensure payment by third party-payers and it is your responsibility to verify coverage if you plan to seek reimbursement. In the event of failure to pay fees, your name, address, and phone number may be forwarded to a University-approved collection agency in accordance with State policies and procedures.

MISSED APPOINTMENT POLICY: Missed sessions are problematic for both clients and therapists. Therefore, we ask clients to make a commitment to attend sessions regularly. If you must cancel a session, call the clinic (512-471-7694) and leave a message for your therapist as soon as possible. You may be charged for missed sessions if you have not notified your therapist at least 24 hours in advance. Frequent cancellations or missed sessions may result in termination of therapy. If you wish to terminate therapy, we encourage you to discuss this decision with your therapist.

IN CASE OF EMERGENCY: The Clinic does not have 24-hour emergency coverage. In the event of an emergency, you may contact any of the following resources if you are in need of urgent care:
1. Call 911 or the Emergency Department of the hospital nearest to you and ask to speak to the psychiatrist or crisis worker on call.
2. UT students may contact UT Counseling and Mental Health Center at (512) 471-3515.

SUMMER AVAILABILITY: Graduate student therapists are officially assigned to clinical training rotations at the Clinic from September through May only, although they may continue to see clients beyond that time frame on a limited basis. If you wish to continue sessions during the summer and your therapist is not available, we will assist you in finding alternate treatment resources.
HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections for treatment records and establishes patient rights with regard to the use and disclosure of your Protected Health Information (PHI). PHI is your medical, billing and demographic information collected and created or received by the Clinic for the purposes of treatment, and payment. HIPAA also permits use of PHI for teaching purposes. HIPAA requires that the Clinic provide you with a Notice of Privacy Practices. Our Notice, which is included with this document, explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that the Clinic has provided you with this information.

LIMITS ON CONFIDENTIALITY: Both Texas and federal law generally protect the privacy of communications between a client and a psychologist. In most situations, the Clinic cannot release information about your treatment to others unless you sign a specific written authorization or consent. However, there are certain situations in which the Clinic is mandated or permitted to disclose confidential information without your consent or authorization. These situations are outlined in the attached Notice of Privacy Practices. If such a situation arises, your therapist will try to contact you before taking any action and will limit disclosure only to the information minimally necessary in the situation.

CONSENT AND ACKNOWLEDGEMENT: I understand I have the right to review the University’s Notice of Privacy Practices prior to signing this document. This Notice describes the types of uses and disclosures of my PHI that may occur in my treatment, payment of my bills or in the performance of health care operations of the Clinic. The Notice also describes my rights and the Clinic's obligations with respect to my PHI. In addition to the copy that I receive today, the Notice is also provided on the Clinic's website at http://asc.utexas.edu. The Clinic reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by accessing the Clinic's website, calling the Clinic office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

I consent to the use and disclosure of my Protected Health Information by the Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment, and/or conducting health care operations of the Clinic. I understand that diagnosis or treatment of me by the Clinic is conditioned upon my consent as evidenced by my signature on this document.

I may revoke my consent in writing at any time. That revocation will be binding when received by the Clinic except to the extent a) the Clinic has already taken action in reliance on my consent, b) the Clinic has legal obligations imposed by a court of law or by my health insurer that makes continued use and/or disclosure of my PHI necessary in order to process claims made under my policy, or c) I have not satisfied financial obligations to the Clinic that I have incurred.

My signature on this document is my consent for treatment and payment and my acknowledgement that I have been informed about and received a copy of the Notice of Privacy Practices.

Name    Signature    Date
Client:  

Therapist:  

Supervisor:  

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