UNIVERSITY of MARYLAND
CHILDREN'S HOSPITAL

University of Maryland's Care Clinic
Consent for Adult Treatment

Consent for Treatment

I, the undersigned, am _____, date of birth: _____. I hereby authorize University of Maryland Center for Families Care Clinic to provide me the following services, as needed:

- Comprehensive Assessment
- Treatment
- Psychiatric Consultation

It is my understanding that treatment consent may be revoked at any time by notifying my therapist.

Initial: _____

Expectations of Services

People often seek mental health treatment for a variety of reasons. Successful mental health services can have many benefits, including (but not limited to) the following:

- Improved social relationships
- Better control of emotions and behavior
- Decreased suicidal/homicidal ideation
- Improvement of other symptoms

Often times, however, as treatment progresses, there may be momentary periods of distress due to (among other things):

- Changes in routine
- Homework assignments
- Challenges to core beliefs
- Processing of trauma

Although the client may experience some distresses, it is important to note that this is part of the therapeutic process. In many cases, this discomfort is normal and expected. An important part of the therapeutic process is open communication between the client and clinician. Thus, it is the client's responsibility to communicate any concerns or other feedback as they arise. In turn, the clinician(s) involved will do their best to accommodate for these concerns.

Initial: _____

Student Clinicians

Along with the goal of providing high-quality services, the Care Clinic also has a goal of providing valuable training, supervision, and consultation to its therapists and medical students/residents. Observations are a standard part of our practice, however if you do not wish to be observed you may let your therapist know at any time. Also, some or all of your clinical services might be provided by a student clinician. All students are supervised and operate under the licenses of licensed mental health professionals. Current supervisor credentials and contact information are as follows:

April Rectanus, MA, LCPC	Randy Chang, Psy.D.	Jacqueline Blair, LCMFT
Clinical Director	Clinical Assistant Professor	Care Clinic Therapist
Licensed Clinical Professional Counselor	Licensed Psychologist	Licensed Marriage and Family Therapist
(MD LCPC License # LC2018)	(MD Psychologist License #04699)	(MD LCMFT #LCM515)
arectanus@peds.umaryland.edu	rkchang@peds.umaryland.edu	jblair@peds.umaryland.edu
410-706-1142	410-706-4869	410-706-4869

Initial: _____

Confidentiality of Services:

Patients are entitled to the confidence that they may speak freely and their privacy will be protected. We have an ethical and legal responsibility to maintain and protect confidentiality. We will not release information to any party unless a specific "Release of Information" form is signed. There are, however, a few circumstances in which confidentiality cannot be maintained. The most common instances are:

- ✓ If you present a danger or threat to yourself or someone else, we are obliged to contact others, including law enforcement authorities and emergency medical personnel, as appropriate.
- ✓ If we become aware of child or elder abuse or neglect, we are under legal obligation to contact the proper authorities.
- ✓ When there is involvement with a Court of Law, records may be subpoenaed and/or a judge may court order disclosure from the record if it is determined that the clinical record should be considered as a factor in the case.
- ✓ Clinical information can and generally will be shared among service providers at the Care Clinic, unless otherwise specified.

Initial: _____

Record-Keeping and Maintenance:

All files are kept within the Care Clinic and will not leave clinic grounds without expressed written permission of the client(s). Should a therapist leave the clinic, the client files will remain with the Care Clinic, as opposed to traveling with that therapist. In cases of Family Therapy, there is a possibility that family members' names might be included within the file, though clinicians will make efforts towards minimizing the amount of personal information contained in that file. If the client or caregiver wishes a copy of records, a written request for records may be required. As is the general standard of practice, the clinician will review the request, and depending on the nature of the request, the clinician may elect to instead provide a written summary of the file.

Initial: _____

Attendance Policy

In order to be as helpful as we can to all of our clients, we have established the following guidelines for missed appointments:

- ✓ If you need to cancel an appointment, we ask that you kindly call us 24 hours before your scheduled time or as soon as possible for emergencies or illness.
- ✓ If you do not show for an appointment twice within 1 month we will not hold your regularly scheduled appointment time for you. Please call and schedule another appointment with your therapist based on your therapist's availability.
- ✓ If, after 3 sessions, you have attended your appointment or given notice prior to any missed appointments, you will once again be offered a regularly scheduled weekly appointment time.
- ✓ If you have not attended an appointment for at least 1 month and do not have an appointment scheduled, you will receive a letter from your therapist informing you that we are closing your file; other referral options will be provided to you in that letter.

If you have any questions about this policy, please call or speak to your therapist.

Initial: _____

Contact with your therapist:

All therapists can be reached at 410-706-4869 and have confidential voicemail. It is against our policy for therapists to text clients and email may be used for scheduling purposes only. For all other issues please call the therapist at the clinic or speak to them during the session. Although voicemails can be left at any time, therapists will only return calls during their business house. For emergencies after hours, please call 911 or go to the nearest emergency room.

Initial: _____

My signature below indicates I have read and understood the above, and am in agreement with these stipulations.

_____ _____

Signature of client Date