



Jesse G. Harris, Jr.  
Psychological Services Center  
Department of Psychology  
644 Maxwellton Court  
Lexington, KY 40508-3225  
859 257-6853  
[www.uky.edu](http://www.uky.edu)

## NOTICE OF PRIVACY AND CLIENTS' RIGHTS

On your first visit to the Jesse G. Harris, Jr. Psychological Services Center (PSC), you are asked to complete paperwork and meet with one of our staff members. This initial appointment is designed to ensure that we will be able to appropriately meet your needs. Whether you are seeking therapy or a psychological evaluation, this initial session is not a guarantee that you will receive services. All potential clients must be reviewed by the PSC Director. Individuals may be referred to other agencies if it is determined that the graduate student clinicians at the PSC are not able to provide the appropriate services for your care. In addition, you should be aware that the staff member who meets with you during your initial consultation may NOT be the clinician who assists you if you are accepted for services.

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1. We must keep your health information from other people who do not need to know it.
2. You may ask that we not share certain health care information. You must make your request in writing. In some instances we may not be able to agree with your request. If that happens, we will explain the reasons to you.
3. You may ask that we contact you at a location that you name (i.e. P.O. Box, family member's house) in the manner you prefer (i.e. telephone or mail).

Because the confidentiality of our clients is so important, we request that you respect the confidentiality of others whom you might encounter while in our offices. Please do not discuss with others what/whom you have seen or heard in our offices.

### USE OF YOUR INFORMATION

**Your private health information may be used by our clinicians and their supervisors.** They may need your private health information to plan your care. We share information about you on a need-to-know basis in order to help you get services you may need.

**We may also use information about you to judge how well we do our job and for other performance improvement efforts within the center.** For example, we may use information to review our services and to evaluate the performance of the clinicians. We may also combine information about many clients to help us decide what additional services we may need to offer or what services are no longer needed.

**You have a right to a copy of your medical record.** Your first copy is free; after that we may charge a fee for additional copies. We will keep your records in a secure place for at least 7 years after you complete services here (if you are 18 years of age or older) or until a child client reaches age 21.

Our goal is to keep your information up-to-date and to correct inaccurate information. If you think some of the information is wrong, you may ask that it be changed or that new information be added. This is called an **amendment**. You may ask that the amendment be sent to anyone else who has received your health information from us. Your request must be in writing and you must provide a reason that supports your request. We must act within 60 days of receipt of your written request. We may deny your request if:

1. it is not made in writing
2. you do not include a reason to support your request
3. the information was not created by us
4. the information is not part of the record kept by or for us
5. the information is accurate and complete

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- 2) **If you tell us information which gives us reason to believe that any person is being abused or neglected**, we are obligated by law to report this to the appropriate state agency which handles such cases.
- 3) **If you are involved in litigation of any kind** and inform the court of the services that you received from us (making your mental health an issue before the court), you may be waiving your right to keep your records confidential. You may wish to consult with your attorney regarding such matters before you disclose that you have received treatment.
- 4) **If you fail to pay your fees in a timely manner**, we reserve the right to provide identifying information (such as name, address, social security number, dates of service, and amount owed) to a collection agency.

Finally, there may be several other instances in which issues regarding confidentiality may be quite important; typically, these will be discussed when the need arises. Examples of such situations are family or couples therapy, and when children under age 18 are seen in therapy.

**If you would like your information to be sent somewhere else, you will be asked to sign a separate form called an *Authorization to Release Information*, allowing your health care information to go to someone else such as another provider.** Your authorization tells us what information is to be sent where and to whom. This authorization is good for 60 days or until the date you put on the form. You can cancel the authorization or limit the information sent by letting us know in writing. After we receive your cancellation, we will not share any more information, but it cannot be helped if information was shared before your request was received.

**You also have the right to request restrictions on the information we use or disclose about you for treatment, payment or healthcare operations. We are not required to agree.** However, if we do agree we will comply with your request unless the information is needed to give you emergency treatment. To request restrictions, you must make your request in writing. In your request you must state:

1. What information you want to limit
2. Whether you want to limit our use, disclosure or both
3. To whom you want the limits to apply (i.e. disclosure to your spouse).

**You may ask for a list of any places where health information may have been sent.** Exclusions to the list would include disclosures for: treatment, payment purposes, to make sure you received quality care, or to make sure laws are being followed. We also will not list persons or facilities to whom we sent information if you signed an Authorization form allowing us to send the information.

### **COMMUNICATING WITH OUR STAFF**

For a variety of reasons, you may need to contact our staff in between your regularly scheduled appointments. This is typically done by calling the center and leaving a message for the staff member to call you back. Sometimes clients may wish to use e-mail to contact our staff. We **STRONGLY DISCOURAGE** the use of e-mail when communicating with our staff. This form of communication is considered unsecure, which means that others might have access to your information if you communicate via e-mail. For your privacy protection, we recommend that you always use a phone for contacting us.

### **CONTACT WITH CLIENTS OUTSIDE THE OFFICE**

Our staff will not see you on a social basis or enter into any business or other relationship besides the professional one, no matter how rational or beneficial it may seem at the time. If you and one of our staff meet on the street or socially, our staff will not speak unless you speak to him/her first, in order to preserve the confidentiality of your services with our center.

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3) **Privacy Complaint.** If you think we have not protected your privacy and wish to complain to the Harris Psychological Services Center, send your complaint in writing to:

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Nothing will happen to you if you file a complaint. It is against the law for us to take any retaliatory or any other negative action against you if you file a complaint.

4) **Non-discrimination policy.** In our professional practice as mental health providers, we do not discriminate in accepting or providing services based on age, gender, race, ethnicity, religion, national

origin, language, disability, sexual orientation, gender identity or expression, socioeconomic status, or any basis prohibited by law. This is both a personal commitment and is made in accordance with Federal, state and local laws and regulations. If you believe you have been discriminated against, please bring this matter to our attention immediately.

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**We will be happy to discuss any questions you may have about the information described on this sheet.**

**I have read the above information and understand it satisfactorily. I have had an opportunity to discuss any questions about the information.**

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Signature of Client (or Legal Guardian)

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**Consent Form**

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In order to provide high quality supervision, services conducted at the Center will be audio- or videotaped, or occasionally observed by a limited number of faculty and qualified students from the center. In addition, supervision and training functions require that sessions be discussed among the Center staff as appropriate for optimal client care and graduate student training.

Client records and other information will be managed at the Center with strictest confidentiality. Please see the separate Clients' Rights form for further detail about our policies.

The staff of the Center frequently conducts research which will help us learn as much as possible about the process and outcome of psychotherapy. Data obtained from psychological tests, interviews, progress notes, and audio and video recording, and diagnoses may be used in such research. This research typically involves no further time or participation on your part beyond the procedures already involved in our clinical services. The information we are interested in is typically already contained your clinical records. The information contained in your records is always kept absolutely confidential. As a result, your identity will be coded numerically on any information used in research, so that you can be assured of anonymity. If you prefer not to have your file data used in research studies, you may indicate so. Choosing not to allow your data to be used in research studies will have no impact on your services at the center.

*(please initial one)*

- I am willing to allow access to my data for research studies.
- I would prefer my data not be used in research studies.

If you miss three consecutive therapy appointments or are not seen for any services for thirty days or longer, the Center reserves the right to discontinue services and assist you with a referral for services at another agency.

I have read and considered the above information. I have been given the opportunity to ask questions about the information in this form, and my questions have been answered to my satisfaction. I voluntarily give my consent for \_\_\_\_\_

(name and relationship) to participate in the treatment program of the Jesse G. Harris, Jr. Psychological Services Center of the University of Kentucky's Department of Psychology.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(Client or Legal Guardian)

Witness \_\_\_\_\_



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### Fee Agreement for Therapy Services

I understand that the fee for the initial appointment should be paid immediately at the time of the appointment. Also, I have been told what the standard fees are for the therapy services I am seeking, and I understand that I may request a reduced fee if I have current financial concerns or limitations.

I understand that payments for services are to be made when I arrive at the Center prior to each appointment unless I have made other arrangements. I agree to pay \$5 for each appointment that I cancel less than 24 hours in advance, and I agree to pay my full therapy session fee for appointments that I do not keep and do not cancel in advance.

I will talk to my therapist and Center staff about any problems that arise concerning making payments or a need to delay payments. I understand that services may be suspended if I do not make payment for a period of 5 sessions.

I understand that the Center does not accept insurance, will not provide information to health insurance companies, and that typically health insurance companies will not reimburse me for any services provided by the Center.

I further understand that the Center reserves the right to release information to a fee collection agency if a delinquent balance is not paid within a timely manner.

All payments may be made with cash, check or credit card.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

**HARRIS PSYCHOLOGICAL SERVICES CENTER CLIENT INFORMATION FORM (CHILD)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Personal/Demographic Information**

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sexual orientation: \_\_\_\_\_

Parent Marital Status (mark all that apply):

\_\_\_\_\_ Single/Never Married

\_\_\_\_\_ Married/Partnered If so, how long? \_\_\_\_\_

\_\_\_\_\_ Cohabiting If so, how long? \_\_\_\_\_

\_\_\_\_\_ Separated If so, how long ago? \_\_\_\_\_

\_\_\_\_\_ Divorced If so, how long ago? \_\_\_\_\_

\_\_\_\_\_ Widowed If so, how long ago? \_\_\_\_\_

\_\_\_\_\_ Other (Please indicate): \_\_\_\_\_

**Contact Information**

Address: \_\_\_\_\_  
\_\_\_\_\_

Preferred Telephone Number: \_\_\_\_\_ (Cell/Home/Work/Other)

Best time to Call: \_\_\_\_\_

Can we leave a message? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, with whom? \_\_\_\_\_

Alternate Telephone Number: \_\_\_\_\_ (Cell/Home/Work/Other)

Best time to Call: \_\_\_\_\_

Can we leave a message? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, with whom? \_\_\_\_\_

Person to be contacted in case of an emergency:

Name/Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_



**Medical History**

Current Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Current medical conditions: \_\_\_\_\_

Medications the child takes regularly: \_\_\_\_\_

Previous hospitalizations (medical or psychiatric):

Date	Location	Reason	Length of Stay
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Serious illnesses (past or current):

Dates	Nature
_____	_____
_____	_____
_____	_____

Previous mental health assessment or treatment:

Date	Location	Brief description of problem	# Visits/Length of Time
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Family**

Child's Father: \_\_\_\_\_ Living? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes: Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current residence: \_\_\_\_\_

How often does the child have contact? \_\_\_\_\_

If no: His age at death: \_\_\_\_\_ Child's age at his death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Child's Mother: \_\_\_\_\_ Living? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes: Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current residence: \_\_\_\_\_

How often does the child have contact? \_\_\_\_\_

If no: Her age at death: \_\_\_\_\_ Child's age at her death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

List below the people now living with the child:

Name	Age	Relationship to child	Occupation

Child's brothers and sisters (if not listed above):

Name	Age	Occupation	Residence (city)	How much contact?

List below any not previously listed people the child has lived with for a significant time:

Name	Age	Relationship to child	Occupation

**Educational, Occupational, and Financial History**

Highest grade child has completed in school: \_\_\_\_\_

Currently enrolled in school? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, where? \_\_\_\_\_

Current and previous jobs child has held:

Job title	Employer (company name and city)	Approximate dates
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Annual family income (mark one):

<input type="checkbox"/> \$75,000 or more	<input type="checkbox"/> \$25,000 - \$29,999	<input type="checkbox"/> \$7,000 - \$9,999
<input type="checkbox"/> \$50,000 - \$74,999	<input type="checkbox"/> \$20,000 - \$24,999	<input type="checkbox"/> \$6,999 or less
<input type="checkbox"/> \$40,000 - \$49,999	<input type="checkbox"/> \$15,000 - \$19,999	
<input type="checkbox"/> \$30,000 - \$39,999	<input type="checkbox"/> \$10,000 - \$14,999	

**Present Difficulties**

If a single major problem could be eliminated, what would it be for your child?

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What prompted you to contact the Psychological Services Center at this particular point in time?

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What does your child like? What things, persons, situations, or activities give him/her pleasure?

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What specific things, persons, situations, or activities make your child upset, uncomfortable, tense, anxious, or blue?

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What is your child likely to do when upset, uncomfortable, tense, anxious, or blue?

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What are your child's personal strengths? Please be specific.

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What are your child's personal limitations? Please be specific.

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Please describe any difficulties or other information not mentioned above which you think might be of assistance to us in understanding and helping your child.

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*WE APPRECIATE THE TIME YOU HAVE TAKEN TO FILL OUT THIS FORM!*



**CLIENT CONTACT INFORMATION**

**Name of Client:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Person to be Contacted in Emergency:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

## Research at the Harris Psychological Services Center

The Jesse G. Harris Psychological Services Center is the training clinic for the doctoral program in clinical psychology at the University of Kentucky. One important role of the PSC is to provide experience in psychotherapy to advanced doctoral students in the program. A second, less well-known role, is to provide a setting for research into assessment and therapy in a clinical setting.

Faculty and graduate students in the clinical psychology program conduct research on issues pertinent to diagnosis and treatment of psychological problems. In particular, graduate students in the clinical psychology program are required to complete a thesis study for their Master's degree, and a dissertation for their Doctorate. Faculty, and students who are attempting to complete their research projects at the PSC, are very grateful for the participation of clients in their research projects. Client participation in research projects in clinical psychology is one justification for the reduced, sliding scale fees charged at the PSC.

In general, research projects at the PSC consist of paper and pencil type questionnaires that typically involve only 1 - 3 hours of your time, arranged around your schedule. Some projects may involve other types of data collection. In all cases, the researcher will thoroughly explain the project to you and answer any questions you might have prior to beginning the study. Your participation in research projects at the PSC is anonymous, and your therapist will not be told of your involvement or your results without your permission.

Remember that your participation in research is not a condition of treatment at the PSC, and you may discontinue involvement in any project, at any time, without penalty.

If you are willing to consider participation in research projects at the PSC on a case by case basis, please sign below to indicate that a researcher may contact you to explain his or her study and determine if you would be willing to take part.

\_\_\_\_\_ Please do not contact me in any way about research opportunities

\_\_\_\_\_ You may contact me about research opportunities per my preference indicated below:

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Clinic Staff Member

\_\_\_\_\_  
Date

### Please fill in all appropriate spaces:

\_\_\_\_\_ You may call me at \_\_\_\_\_ phone number(s).

The best times to reach me are \_\_\_\_\_.

You may leave a message with \_\_\_\_\_.

\_\_\_\_\_ Please do not leave a message.

\_\_\_\_\_ You may write to me at \_\_\_\_\_ (address).