



CONSENT

I, \_\_\_\_\_, consent to receiving psychological treatment and counseling services from the Psychological Services Center (PSC) of the University at Albany, State University of New York.

I understand that I will be assessed and counseled by doctoral students in the Department of Clinical Psychology or the Department of Educational and Counseling Psychology at the University at Albany, State University of New York. I also understand that these students will be supervised by the Director of the PSC or by faculty members of the Department of Clinical Psychology or the Department of Educational and Counseling Psychology at the University at Albany, State University of New York. As part of this supervision, the treatment I receive may be observed by faculty and other graduate students being trained at the PSC.

I understand that I may ask any questions that I may have about my assessment or counseling at any time and that I may withdraw my consent to treatment or counseling at any time. I further understand that all information pertaining to my treatment shall not be released to anyone outside of the PSC, except pursuant to my permission or when such release is otherwise required by law.

As part of your usual care, we would like to collect information about you and your progress in treatment. There is the possibility that we would use that information for the evaluation of our services, but you must consent for us to be able to do so. If you do not want us to use your data, your care will not be affected in any way. If we do use your information, it will not be associated with your name. There will be no information that could personally identify you. Please initial here if you permit this information to be used for evaluative purposes. \_\_\_\_\_

I understand that the PSC is open for clinical services from 1:00 pm to 8:00 pm, Monday through Thursday, with the exception of state holidays. I understand that the PSC is not a clinical resource after working hours or on weekends. In the event that an emergency arises when the PSC is closed, there are clinical resources available in the community, including hospital emergency rooms or the Capital District Psychiatric Center's Crisis Unit located at 75 New Scotland Avenue in Albany. The telephone number at CDPC is (518) 549-6500.

I understand that all fees are payable at the beginning of each session. I understand that I must notify the PSC at least 24 hours before my scheduled time if I am going to cancel my appointment; otherwise, I will be responsible for the session fee. If there are three (3) failures to notify the Center 24-hours in advance of an appointment, services will be terminated, barring unusual circumstances.

Signed: \_\_\_\_\_

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

Witness: \_\_\_\_\_

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