

KU Child and Family Services Clinic

2021 Dole Human Development Center
1000 Sunnyside Avenue
University of Kansas
Lawrence, KS 66045-7555

Telephone: 785-864-4416
Fax: 785-864-1935

GENERAL CONSENT FOR PSYCHOLOGICAL SERVICES FOR CHILDREN AND ADOLESCENTS

Child's Name _____

Therapist's Name _____ Supervisor's Name _____

1. I understand that this is a teaching facility and that training clinical psychologists is the major activity of the clinic. I authorize the Clinic to make videotaped and/or audiotaped recordings as deemed appropriated for teaching and research purposes. I understand that supervisory staff and students in training may observe sessions (on tape or live). I understand that I will be told when tapings and/or observations are taking place.
2. I understand that part of the education of clinical psychologists involves their learning how to administer and interpret psychological tests and that I may be asked to agree for me or my child to take certain psychological tests that are primarily for the student therapist's training. I also understand, however, that the nature and purpose of such testing will be explained to me in advance and that I will not be charged for any testing done for training only.
3. I understand that all Clinic files are confidential and that the Notice of Privacy Practices I have received governs release of information by the Clinic to other persons or agencies.
4. I understand that I may be asked to sign consent forms for the release of social, medical, and/or psychological information from other agencies or individuals for use by the staff of this Clinic in my own or my child's treatment and/or assessment.
5. I understand that research takes place in the KU Child and Family Services Clinic. I understand that no research directly involving or identifying me and/or my child will be conducted without my knowledge and specific informed consent.
6. I understand that this Clinic is open from 1:00 p.m. to 7:00 p.m. on Mondays, Tuesdays, Wednesdays, and Thursdays, noon-6:00 p.m. Fridays, and mornings by appointment to conduct assessments and that it does not offer after-hours or weekend services. My therapist and I will set my appointments.

7. I am aware that the practice of clinical psychology and related disciplines is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatments, assessments, and consultations.
8. I understand that some types of problems respond to medication, either alone or along with psychotherapy. I am aware that clinic supervisors are licensed clinical psychologists, with a doctoral degree in clinical psychology, and that the clinic therapists are students of clinical psychology. They are not medical doctors; therefore, they do not prescribe medications and are not authorized to practice medicine or surgery. If my therapist thinks that my child should consider medication as a part of treatment and I want to try this, my therapist will refer us to a physician with whom they would work to provide coordinated services. I understand that psychological problems can have medical or biological origins and that Clinic staff strongly encourage my child to have regular physical exams and to speak with the doctor about all of his or her symptoms.
9. I consent for myself and/or my child to undergo all testing and treatment procedures necessary to address the problems for which I am seeking help. I understand that I have the right to be informed of the nature and purpose of any procedure and that I can refuse or discontinue testing or treatment at any time.
10. I understand that I am responsible for the payment of any fees for services that I consent to and that failing to pay such fees may result in the termination of any further services to me. If I am a KU student, I understand and agree that a hold may be placed on my grades, transcripts, and future enrollment until such fees are paid.
11. I understand that special arrangements may need to be made regarding payment and reporting of assessment and treatment results in cases of divorce, foster care, and court-mandated services.
12. I understand that I must remain in the clinic while my child is receiving treatment in the Clinic. I understand that I am not able to drop my child off for his/her therapy or assessment session and pick them up at the end of the session. I must be physically present in the Clinic while my child is in session.
13. I acknowledge that I have been given a copy of this consent form to keep for my own records.

Signature of Therapist or Witness

Date _____

Signature of Guardian or Legal Representative

Date _____