



## Telemental Health Services Collaborator Consent

Telemental Health Services at Health Services is the practice of delivering non-emergency mental health counseling from a distance via video conferencing. This service is delivered face-to-face synchronously with the client and licensed clinician in different physical locations within the state of Idaho. Home-based therapy requires a third party on the premises to provide timely and efficient intervention in certain circumstances outlined below.

### Collaborator:

An agreed upon person, by the client and clinician, who is in the locale of the client and available to contact local authorities in the case of an emergency, provide emergency transportation, be a point of contact in the event of lost electronic communication, and troubleshoot technical issues, all on behalf of the client. Collaborators can be the client's family or friend.

### Collaborator Contact Information:

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

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

Printed Client Name: \_\_\_\_\_

### Roles of the Collaborator:

- Be physically located near the client during telemental health sessions
- Be able to contact local authorities in the case of a client emergency. If you are unable or unwilling to complete this step, the clinician will contact local authorities on the client's behalf
- Provide emergency transportation for the client
- Be a point of contact in the event of lost electronic communication involving the telemental health session
- Troubleshoot technical issues that arise during the client's telemental health session

### Confidentiality:

In compliance with applicable Federal Laws and regulations along with Idaho state statutes, all the information obtained during the client's telemental health session will be kept confidential as required by law. Information gathered during the telemental health session will not be revealed to you or anyone else outside of Health Services without the client's consent, unless the situation is deemed an emergency. In that case, only the minimum necessary information will be shared with you, so you can help protect the client if they present a serious and foreseeable threat to themselves or others.



Affix Label Here

**BOISE STATE UNIVERSITY**  
**HEALTH SERVICES**

**COUNSELING SERVICES CONSENT**

Welcome to Boise State University Counseling Services! Our desire is to make your visit with us as beneficial as possible.

**Counseling Services/ Mental Health Provider Credentials:**

All of the providers at Health Services Counseling Services are qualified professionals. The senior staff consists of psychologists, counselors and social workers at the master or doctoral levels with the appropriate credentials and/or licensure. Our staff also includes trainees; this may include **Counseling Graduate Trainees and Social Work Trainees**, who are working toward completion of their master's degree. All of the trainee staff are supervised closely by a Counseling Services senior staff Provider.

**Fees and Billing Process:**

Health Services will bill your insurance company for the care you receive from Counseling Services. Patients are responsible for ensuring that they provide Health Services with accurate information regarding their insurance status at the time of services. Please note that some or perhaps all of the services you receive may be "non-covered" services, not considered "reasonable and necessary", may be processed as "out of network", and/or may be applied to a "deductible" or "co-insurance" under your insurance plan. Please note that you are fully responsible for all charges associated with care regardless of your insurance benefits. For additional questions regarding billing or fees for service please visit our Health Insurance and Billing Office. A full disclosure of fees for service is available upon request.

Please note that Health Services does charge patients for missed appointments. Please help us serve you better by keeping scheduled appointments and giving 24 hours' notice on any cancellations.

**Counseling Process:**

Health Services is committed to providing you with mental health services that best meet your needs. The frequency of your return appointments may vary and will be established in consultation with your Provider. In order for you to receive the most benefit from your counseling sessions your active participation is required.

Our primary purpose is to help you become effective in dealing with concerns that influence your ability to achieve success in pursuit of personal and academic goals through short term solution-focused services. In the event you need or want long-term counseling services beyond what we can provide, your Provider will assist you in exploring available resources in the community that can best support your care.

**Confidentiality:**

In compliance with applicable Federal Laws and regulations along with Idaho state statutes, all the information obtained during your counseling session will be kept confidential as required by law. Information gathered during your counseling session will not be revealed to anyone outside of Health Services without your consent **except** in the following situations where disclosure is required by law:

- Where there is reasonable suspicion or report of abuse to vulnerable populations, including children, elderly persons, and individuals who are unable to advocate for themselves.
- Where you present serious and foreseeable harm to yourself or others.
- If we receive a subpoena, court order, or as part of legal proceedings which may include but is not limited to legal complaints filed by you against your provider.
- In specific cases of law enforcement emergency for national security issues.

**Medical Record:**

Health Services uses an Electronic Medical Record for all care received at Health Services which includes your medical records, counseling progress notes and appointment history information. Counseling records are the property of Boise State University Health Services. However, you do have the right to access the information contained within your record. Your provider may consult with you regarding the best approach to access information contained within your record. To obtain copies of your records, or if information from your record needs to be transferred to a third party, we ask that you complete an authorization to release information form and submit for processing. If you request your records, all parties present during the counseling session (i.e., family or significant other) would need to consent to the release of the record as well.

\*\*Please note that releasing clinical information about a patient/client could have a negative impact on the therapeutic relationship and potentially become harmful to the patient/client. Patients/Clients are always encouraged to speak with Health Services staff about their record and any implications previous to the release of any information

**Benefits and Risks of Counseling and Assessment:**

Benefits of counseling may include but are not limited to: an improved ability to relate to others; a clearer understanding of self, your values and/or goals; increased academic productivity; and an ability to cope with everyday stress.

While benefits are expected from the counseling process, there may be periods of increased anxiety or uncertainty, which may affect relationships, your job, and/or your understanding of yourself. It is impossible to predict the extent to which you might experience these changes. You and your Provider will work together to maximize the benefits of the counseling process.

Benefits of assessment may include but not limited to: a clearer understanding of self, your values and/or goals, increased academic productivity a clearer understanding of your strengths, limitations and strategies to maximize your potential. Although benefits are expected from the assessment process, it is impossible to predict the outcome of the assessment. ***It is possible that you will not receive the diagnosis you are seeking, or may receive a diagnosis you are not expecting.*** It is also possible that we will not be able to offer you a specific diagnosis or answer your problem(s) through the assessment process. You and your provider will work together to maximize the benefits of this process. Your participation and payment for an assessment does not guarantee any results.

**Your signature below indicates that you have read this agreement, agree to the terms, and have had the opportunity to have your questions answered.**

\_\_\_\_\_  
Printed Client Name

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
University ID Number

\_\_\_\_\_  
Printed Counseling Services Provider Name

\_\_\_\_\_  
Counseling Services Provider Signature

\_\_\_\_\_  
Date



## BOISE STATE UNIVERSITY

### HEALTH SERVICES

#### NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

#### **Protecting Your Personal and Health Information**

Boise State University Health Services (“Health Services”) is required by applicable federal and state laws to maintain the privacy of your protected health information, and to notify affected individuals following a breach of unsecure health information. This notice explains our privacy practices, our legal duties, and your rights concerning your health information. Our duties and your rights are set forth more fully in 45 CFR Part 164. While this policy is in effect, we are required by law to abide by its terms.

#### **Uses and Disclosures We May Make Without Written Authorization**

For certain purposes Health Services may use and or disclose your health information without your written authorization. These include the following circumstances:

- **Treatment:** We may use and disclose your health information to provide treatment to you, or for continuation of treatment activities.  
For Example: We may share your information with another healthcare provider so they may treat you.
- **Payment:** We may use and disclose your health information to obtain payment for services provided to you.  
For Example: We may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.
- **Health Care Operations:** We may use and disclose your health information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care.  
For Example: We may use information to train or review the performance of our staff or make decisions affecting the practice. We may also call you by name in the waiting room when Health Services staff is ready to see you.

#### **Other Uses and Disclosures**

Health Services may also use or disclose your information for certain other purposes as allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid serious threat to your health or safety or the health and safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- For certain public health activities, such as reporting certain diseases.
- For certain public health oversight activities, such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.



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- For certain specialized government functions, such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement, such as to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.
- Scheduling and appointment reminders
- Plan Sponsors: If you are enrolled in the Student Health Insurance Plan (SHIP), we may disclose your health information to the sponsor to permit it to perform administrative activities.
- Underwriting: We may receive, use and disclose your health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of the contract for SHIP.
- If you are a minor: Some state laws concerning minors permit or require disclosure of protected health information to parents, guardian, and persons acting in a similar legal status. We will act consistently with the laws of Idaho and will make disclosures consistent with such laws.
- To your family and/or friends in the event of an emergency.

#### **Disclosures We May Make Unless You Object:**

Unless you notify us otherwise in writing, we may disclose your information as described below:

- For marketing purposes: Such as to inform you of health related products and services or about treatment alternatives that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you with the choice to opt out of those activities. You may also choose to opt back in.
- To maintain a facility directory: If a person were to ask for you by name, we will only disclose if you were seen at Health Services.

#### **Uses and Disclosures With Your Written Authorization:**

Other uses and disclosures not described in this Notice will be made only with your written authorization, including most disclosures of psychotherapy notes (if the provider you saw kept psychotherapy notes), most marketing purposes, or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance of the authorization.

#### **Your Patient Rights Concerning Your Protected Health Information:**

You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the HIPAA Privacy Compliance Officer.

- You may inspect and obtain a copy of your records that are used to make decisions about your care, or payment for your care. We may deny your request under certain circumstances. For example: if we determine that disclosure may result in harm to you or others.



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- You may request that your protected health information be amended. We may deny your request for certain reasons such as: if we did not create the record or if we determine that the record is accurate and complete.
- You may request an accounting of disclosures we have made of your protected health information.
- You may request additional restrictions on the use or disclosure of information for treatment, payment or health care operations. However, we are not required to agree to the restrictions except in the limited situation in which you, or someone on your behalf pays for an item or service in full, and you request that the information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, text message, email, or at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You have the right to obtain a paper copy of this Notice upon your request. You have this right even if you have agreed to receive the Notice electronically.
- You have the right to receive notice of a breach. We will notify you if your unsecured protected health information has been breached.

#### Communication through Email

We ask you not to use your personal email in contacting our staff. Emails sent to and from your personal email address are not secure and could be intercepted by a third party. We strongly encourage you to sign up for a patient portal account where you can read and respond to emails you receive from us, check your lab results, see your appointment summaries and check on your past and upcoming appointments. If you should have further questions we ask that you call our office directly so we can assist with answering your questions and taking care of your needs.

#### Changes to this Notice of Privacy Practices

Boise State University Health Services reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. If we materially change our privacy practices, we will post a copy of the current Notice on our website and all other locations which this Notice is posted. Until such time, Boise State University Health Services is required by law to comply with the current version of this Notice.

#### Complaints

If you have any questions regarding this Notice or if you feel any of your rights listed in this Notice have been violated you may file a complaint with the Secretary of Health and Human Services or by notifying our HIPAA Privacy Compliance Officer. All complaints must be in writing. We will not retaliate against you for filing any complaints.

Attn: HIPAA Privacy Compliance Officer  
Boise State University Health Services  
1910 University Drive  
Boise, ID 83725-1351  
Phone (208) 426-1459  
Fax (208) 426-3005

Office for Civil Rights, Region X-Seattle  
U.S. Department of Health and Human Services  
Linda Yuu Connor, Regional Manager  
2201 Sixth Avenue – M/S: RX-11  
Seattle, WA 98121-1831  
Phone: (206) 615-2297  
Fax: (206) 615-2296

Effective date of this notice: June 11, 2019



BOISE STATE UNIVERSITY

HEALTH SERVICES

## HEALTH SERVICES PATIENT/CLIENT AGREEMENT

Thank you for choosing Boise State University Health Services as your health care provider. We are committed to providing you with quality health care.

**Hours of Operation:** Health Services is open from 8:00am to 5:00pm on Monday, Tuesday, Thursday, Friday, and from 10:00am to 5:00pm on Wednesday. Crisis counseling and urgent care medical services are available during the hours of operation; **no appointment is required.** Crisis counseling and urgent care medical services are meant for situations which cannot wait for a scheduled appointment.

**Consent for Treatment:** I authorize the staff of Boise State University Health Services, their employees, and consultants to undertake such treatment, diagnostic procedures, and medical procedures, which in their judgment may become necessary while receiving care at Health Services. I understand that I will be involved and engaged in my care and treatment; and that I have a right to a full explanation of any treatment or procedures utilized. I am aware the practice of medicine is not an exact science and I understand no guarantees have been made to me regarding the results of treatment or examinations. As a patient/client of Health Services, I understand that individuals being trained for a health care profession may participate in providing me care. I understand that if I require specialized care, emergency care, or care which is out of the scope of services for Health Services I will be referred to the appropriate facility and/or providers. I understand that an emergency contact will be notified of my condition if considered necessary by the professional staff at Health Services.

**Confidentiality and Notice of Privacy Practices Acknowledgement:** Medical and mental health information contained in all health records is confidential and may not be released without express written permission from the patient/client unless certain conditions are met. I understand that Health Services may release my health records (with the exception of psychotherapy notes) for treatment, payment, or health care operations, and for certain other purposes under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable federal or state laws and regulation. I also understand that I have certain rights to privacy in regard to my protected health information (PHI). I understand a copy of the Notice of Privacy Practices (Notice) which provides a comprehensive description of how my health information may be used and/or disclosed is available to me at my first appointment and upon request. I understand that I have the right to review the Notice prior to signing this acknowledgement form. I understand that Health Services reserves the right to change their notice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Health Services may not be required to agree with the restrictions I have requested.

**Financial Agreement and Authorization to Process Insurance Claims:** I give permission for Health Services to file insurance claims on my behalf, and authorize my insurance company to distribute the payment of my coverage directly to Health Services. I authorize the use of my signature below on all insurance submissions.

- **I acknowledge that insurance is a contract between the patient and the insurance company and ultimately I, as the patient, am responsible for the payment in full. I understand that the filing of these claims does not guarantee either full or partial payment by my insurance company.**
- I understand that I must provide Health Services with accurate information on my insurance status at time of service. I acknowledge that Health Services bills my insurance company as a courtesy to me and that some or perhaps all of the services I receive may be “non-covered” services, not considered “reasonable and necessary”, may be processed as “out of network”, and/or may be applied to my “deductible” and/or “co-insurance” under my insurance plan.
- I understand that I am responsible for understanding my insurance plan and benefits, and that Health Services is not responsible for my insurance processing charges out of network or providing me with benefit information from my insurance plan. I understand that some insurance companies require prior authorization for certain services such as mental health consultations and therapy and that it is my responsibility to know if/when my insurance company may require a prior authorization. If you are not familiar with your plan coverage, Health Services recommends that you contact your carrier or plan provider directly.
- I understand that if I am a student, balances which are my responsibility will be transferred to my student account, and that all standard Boise State fees and deadlines will apply to that balance.
- I understand that Health Services is a participating provider for most health insurance plans and will bill your insurance plan as a courtesy. I understand that if Health Services is not a participating provider with your health insurance plan, **which includes but is not limited to:** Medicare, Medicaid, and the VA., payment in full is required at the time of service, unless other arrangements have been made.



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- **I understand that I am fully responsible for all charges at the time of service if I do not currently have insurance coverage or have an insurance that Health Services does not bill at this time.**

**Missed/Late Appointments:** Please help us serve you better by keeping scheduled appointments and giving 24 hours' notice on any cancellations.

- **I understand that I will be charged a fee for any missed appointments with Health Services.**
- **I understand that if I arrive more than 10 minutes late for a scheduled appointment, I will be rescheduled for that appointment.**

Thank you for reviewing our Patient/Client Agreement. Please let us know if you have questions or concerns regarding this information. By signing below, you agree to the information stated above.

\_\_\_\_\_  
Emergency Contact Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Printed Patient/Client Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Client Signature

\_\_\_\_\_  
University ID Number



**BOISE STATE UNIVERSITY**  
**HEALTH SERVICES**

**RIGHTS AND RESPONSIBILITIES**

Boise State University Health Services is committed to supporting and protecting the rights of each of our patient/clients. With these rights also come patient/client responsibilities. Active participation in your health care will assure the best outcomes.

**PATIENT/CLIENT RIGHTS:**

- To accept or refuse any care or treatment and understand the implication of refusal
- To receive fair and equal treatment in all circumstances regardless of your age, race, gender, sexual orientation, or religion
- To be treated with respect, consideration, and dignity
- To receive care in a safe environment
- To privacy of care
- To be informed of your provider's training status, including the limitations and restrictions of services
- To participate in decisions about your care and treatment
- To receive accurate, easily understood information about your health care concerns and the care you are receiving
- To be informed of the purpose, goals, techniques, procedures, limitations, potential risks, and benefits to treatment
- To ask questions about techniques and strategies used
- To work with your provider on a treatment plan you are comfortable with and will adhere to
- To receive education and counseling
- To request to transfer to another provider, when appropriate
- To confidentiality of your records
- To access your medical records
- To have your concerns heard and reviewed in an objective and timely manner
- To receive a copy of this consent form
- To file a complaint without retaliation

**PATIENT/CLIENT RESPONSIBILITIES:**

- To provide accurate information regarding your health history
- To be active in making decisions regarding your care
- To ask questions to seek clarification if you do not understand your treatment plan
- To follow the treatment plan prescribed by your health care provider
- To show courtesy and respect to health care personnel and other patient/clients
- To keep your appointments and arrive on-time
- To cancel or reschedule as far in advance as possible so that the time may be used to treat other patient/clients
- To communicate with your provider if your condition worsens or does not follow the expected course
- To provide useful feedback about services and policies
- To provide accurate information about sources of payment
- To fulfill your financial obligations and to pay for care as promptly as possible
- To inform your health care provider of any advanced directives that could affect your care



**BOISE STATE UNIVERSITY**  
**HEALTH SERVICES**

Providers at Boise State University Health Services also have certain rights and responsibilities related to the care they provide to patients/clients. Creating a mutually respectful relationship with your provider will enhance the care you receive.

**PROVIDER RIGHTS:**

- To establish and maintain mutually respectful relationships with their patients/clients
- To consult with other medical and mental health providers within Health Services, when needed, in order to provide the best care for the patient/client
- To terminate a relationship with a patient/client if that patient/client's care is outside of the provider's scope of practice, or if the patient/client displays disruptive behavior, is a safety concern, or creates an ethical dilemma. In these cases, patients/clients will be provided appropriate referrals that would best meet their needs

**PROVIDER RESPONSIBILITIES:**

- To adhere to all statutes, licensing board rules, and codes of ethics in the provider's field of practice
- To present patients/clients documents related to professional qualifications upon request
- To provide quality services and involve patients/clients in their plan development and evaluation of treatment goals
- To ensure confidentiality of their patient/client's clinical information whenever possible
- To inform the patient/client of provider qualifications, professional disciplines, areas of expertise, and to practice within those standards
- To demonstrate respect regardless of a patient/client's age, race, ethnicity, gender, sexual orientation, religion, and socio-economic status

I have read and understand the rights afforded to me as a patient/client and the responsibilities I have while I receive care.

\_\_\_\_\_  
Printed Patient/Client Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Client Signature

\_\_\_\_\_  
University ID Number



## Teletherapy Informed Consent Form

I hereby consent to engage in teletherapy counseling services with Boise State University Counseling Services. I understand that "teletherapy" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive live audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in the state of Idaho.

I understand that I have the following rights and understanding with respect to teletherapy:

- 1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- 2) I understand that my clinician is licensed in the state of Idaho, and therefore, I will need to attest that I am physically in the state of Idaho for each teletherapy session.
- 3) The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I will need to attest that I am in a private, **non-public**, secure place, and alone for each of my teletherapy sessions.
- 4) I understand that the information disclosed by me during the course of my therapy is generally confidential.

However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting abuse of **vulnerable populations**; expressed threats of violence towards an ascertainable victim; **expressed threat to harm or kill self**; and where I make my mental or emotional state an issue in a legal proceeding **or the involvement of law enforcement**.

I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my written consent.

- 5) I understand that there are risks and consequences from teletherapy. This includes, but is not limited to, the possibility, despite reasonable efforts on the part of my counselor, that technical failures could disrupt or distort the transmission of my medical information; unauthorized persons could interrupt the transmission of my medical information; and/or unauthorized persons could access the electronic storage of my medical information. **In the event of a technical failure, I will have a contingency plan in place with my counselor for a back-up mode of communication to close our therapy session and discuss next steps.**

In addition, I understand that teletherapy-based services and care may not be as complete as in-person face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. **Examples include, but are not limited to, crisis situations, severe and persistent mental illness, and medication management.**

Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

- 6) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I accept that teletherapy does not provide emergency services. During our first session, the clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand

that I can call 911 or proceed to the nearest hospital emergency room for help. Examples of emergency situations include, having thoughts of hurting or killing either another person or myself, having hallucinations, being in a life-threatening or emergency situation of any kind, having uncontrollable emotional reactions, or being dysfunctional due to abusing alcohol or drugs.

I acknowledge I have been told that if I am having suicidal thought or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.

I understand that my counselor may ask me to have a ‘collaborator’ on my premises, who is available to contact local authorities in an emergency. A collaborator can be family or friend. My counselor and I will determine who will be designated as my local collaborator, obtain their contact information and consent, discuss their responsibilities, and circumstances for contacting them.

7) I understand that I have a right to request access to portions of my medical information and copies of medical records in accordance with Idaho law and HIPAA privacy and security rules.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
University ID Number



**BOISE STATE UNIVERSITY**

**HEALTH SERVICES**

### **Consent to Observe/Record Counseling Services Sessions**

Counseling Services at Health Services is a training facility that supports the learning and development of graduate interns and supervised licensed providers. Recording and/or live observation of group and/or individual sessions is part of this program for the purposes of education and training. You are providing your informed consent for observation and/or recording of therapy sessions. If you have any questions about this process, we encourage you to speak with your therapist.

NOTE: Due to the requirements of our training program, you may be reassigned to another provider if you do not give your permission to record your appointments. Your decision not to be recorded/observed will not affect your eligibility for services, but may affect the timeliness of services.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
University ID Number

1910 University Drive Boise, Idaho 83725-1351

Phone (208) 426-1459 Fax (208) 426-3005