APPENDIX D – INFORMED CONSENT

Consent:
Your signatures and initials below indicate that you consent to enter therapy through an informed decision. This document will serve as the contract between the client and the Olson Clinic. This document outlines clinic procedures, client/Student Therapist relationships and serves as a guideline for our working relationship.

The Gerald & Audrey Olson Marriage & Family Therapy Clinic (Olson Clinic) is a teaching-clinic, and therapy is conducted by students under the supervision of Licensed Marriage and Family Therapists and AAMFT-approved Supervisors/Supervisor candidates. In order to provide the best services possible, sessions are subject to video recording or observation by clinic Supervisors or other students in the Olson Clinic. Supervisor/Clinical Director may deem it important or necessary to be part of/join/conduct sessions at the Olson Clinic. All Student Therapists and faculty Supervisors are required to uphold the Code of Ethics of the American Association of Marriage and Family Therapists and Iowa Law. Copies of these codes are available upon request.

The Olson Clinic cannot make recommendations on or conduct evaluations for custody of children. The Olson Clinic cannot provide primary treatment for active substance use and abuse. The Olson Clinic cannot see clients that are experiencing active psychosis.

I understand therapy sessions are video and audio recorded for review at the Olson Clinic, and in signing this informed consent, I agree to allow The Olson Clinic to record my sessions.

I understand that The Olson Clinic is not a crisis center and is not staffed or qualified as one. I agree that if I am in crisis or assessed to be in crisis, the clinic staff and/or Student Therapist will refer me to or call crisis management on my behalf, which could include 911, police and/or mobile crisis.

I agree to enter the therapy process aware that there may be potential for emotional strains, stresses, and life changes as a result of therapy. I agree that The Olson Clinic does not guarantee any particular results or outcome from the therapy process.

When I do decide to terminate therapy, I agree to discuss this decision in a regular session with my therapist. Due to the nature of this clinic, if a file goes 30 days with no activity, it will be closed. I am still responsible for all unpaid fees at the time of closure. In the event that I wish to attend therapy again in the future, the file may be reopened by calling (319-368-6493).

I understand that "The Good Faith Estimate" which is given to me during intake for my personal records includes personal health information. During the course of treatment, there may also be other documents provided to me by my therapist that include personal health information. When such document(s) are given to me, I understand that I am responsible for safeguarding their contents as I see fit. I will not hold the Olson Clinic and/or its staff members/providers liable for any information that may be seen by another party on forms and documents from the Olson Clinic that are in my possession.

You will provide your initials on each page of the Informed Consent to indicate your understanding of their contents. Each adult who is present for the session—not just the client on file—should provide their initials. Thus, up to 6 spots for initials are provided in the case of large therpay groups.

Initials _____ _____ _____ _____ _____ _____

Cancellations and Associated Fees:
24-hour notice is required for all cancellations. If appropriate notice is not given, 50% of your session fee will be charged to your file. After three cancellations with less than 24-hours' notice, your file may be closed. In the case of a returned check, a $25 fee will be added to the account.

HIPAA:
I acknowledge I have received, have read (or had read to me), and understand the contents of The Olson Clinic Notice of Private Practices. I fully understand its contents, and if I had any questions regarding this document, they have been fully answered.

Confidentiality:
All Student Therapists and faculty Supervisors are required to hold information about sessions and clients in confidence. The Olson Clinic will not disclose client information without the expressed written consent of every member involved in treatment. This means that if more than one person is involved in treatment, all individuals associated with that treatment must sign a release of information before any information will be provided for use outside the clinic. This applies to all session types: in-person, telehealth, or phone.

The exceptions to confidentiality policies are the following circumstances:

1. If there is clear and imminent danger to you or others, in which case either clinic may be required to inform the responsible authorities or warn the identified victim. In this event, the therapist will inform you of their responsibilities and actions.

2. In situations of suspected physical, emotional, or sexual abuse of a child, elderly or dependent adult abuse, therapists are required to submit a report to the Department of Human Services and may be required to contact authorities. Again, in this situation, you would be informed of the therapist's responsibilities and actions.

3. The clinic maintains records of treatment, diagnosis, assessment, and treatment planning in order to collaborate with Clinic Staff (Clinic Staff includes Student Therapists, Supervisors, Administrative Assistants, and Clinic Interns or Work Studies) to better inform your treatment and assess the effectiveness of treatment provided. You may request restrictions as to how your case information may be used or shared among clinic staff; however, the Olson Clinic is not required to agree to those restrictions.

4. As the Olson Clinic is a training facility, you agree that staff, clinical supervisors, and other therapists may have access to confidential information for the purpose of clinical effectiveness.

5. Some litigation may require the release of records even without the client's authorization. Student therapists will not typically testify in court (unless mandated) as this is outside of their scope of training, and they are not qualified to do so.

Research:
I am aware the Olson MFT Clinic uses all client paperwork and video/audio recordings for academic research purposes. **No identifying information is used for this research, including name, date of birth, address, etc.** Each client will be randomly assigned a number to ensure confidentiality further, and all paperwork and recordings will be kept in a safe and secure location within the clinic. When needed, video recordings will be coded for research purposes, but no raw footage will be used. If at any point, you would like to withdraw your information from the data that is being collected, you are able to do so by letting your therapist or the front office staff know. There are no known risks associated with the collection of this data.

Initials _____ _____ _____ _____ _____ _____

SESSIONS

Sessions will be conducted in either in-person or telehealth/phone sessions. The session type will be determined by the client and Student Therapist. They will strive to honor your preferences so long as they are feasible and clinically appropriate. There may be some situations where your student therapist, or supervisor/clinical director, may require that you meet via telehealth only. If you have concerns about meeting through telehealth, they will discuss it with you and attempt to address your concerns.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision as long as it is feasible and clinically appropriate.

Depending on session type, the client will adhere to the following guidelines:

IN-PERSON SESSIONS GUIDELINES RELATED TO THE CORONAVIRUS

MMU, and/or The Olson Clinic cannot guarantee that you, your partner, or your child(ren) will not become infected with COVID-19 as a result of entering MMU, and/or The Olson Clinic. Further, attending in-person sessions could increase your risk, your partner's risk, and your child(ren)'s risk of contracting COVID-19.

RISKS OF OPTING FOR IN-PERSON SERVICES

I acknowledge the contagious nature of COVID-19. I voluntarily assume the risk that myself, my partner, and my child(ren), and I may be exposed to or infected by COVID-19 by attending in-person sessions and that such exposure or infection may result in personal injury, illness, permanent disability, and death.

By initialing, you understand that MMU, and/or The Olson Clinic have zero control over whether or not those other individuals are taking action to minimize exposure or protect you from COVID 19, and you will not hold MMU, The Olson Clinic and/or the personally liable of actions/inactions other individuals have/have not taken to limit the spread of infection.

I understand that the risk of becoming exposed to or infected by COVID-19 at MMU, and/or The Olson Clinic may result from the actions, omissions, or negligence of myself and others, including, but not limited to, MMU, and/or The Olson Clinic staff/employees, faculty, volunteers, students, and other professionals are working in the building, practicum students, or other clients/persons who were in the building.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself, my partner, or my child(ren) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I, my partner, or my child(ren) may experience or incur in connection with my, my partners, or child(ren)'s attendance at MMU, and The Olson Clinic ("Claims").

On my behalf, and on behalf of my partner, and child(ren), I hereby release, covenant not to sue, discharge, and hold harmless MMU, and The Olson Clinic, its students, faculty, staff/employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.

Initials _____ _____ _____ _____ _____ _____

I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of MMU, and The Olson Clinic, its students, faculty, staff/employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person therapy sessions. I understand and agree to take the risk of exposure to the Coronavirus.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

Wearing a Mask:
Consistent with University guidelines, you are not required to wear a mask during in-person sessions at the Olson Clinic. If your student therapist requests that masks be worn during session, we ask that you respect their wish. Likewise, if you request that masks be worn during session, our student therapist(s) will respect your entreaty.

Before a Session:
If you have a temperature over 100.4 degrees Farenheit or if you have other symptoms of the Coronavirus, you agree to cancel the appointment or proceed using telehealth. If you know you have been exposed to the Coronavirus, you will cancel your session or will move to telehealth. If you wish to cancel for these reasons, you will not be charged our normal cancellation fee.

TELEHEALTH GUIDELINES

Telemental-health involves the use of electronic communications to enable health care providers to share individual patient therapeutic information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient therapeutic records; Therapeutic images; Live two-way audio and video; Output date from therapeutic devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Using Email to Communicate with your Therapist
Due to the risk inherent in HIPAA compliance with the use of any telemental-health or technology devices, please consider the following considering using email to communicate with your Student Therapist or Clinic Staff:

"If individuals are notified of the risks and still prefer unencrypted email, **the individual has the right to receive protected health information in that way**, and covered entities are not responsible for unauthorized access of PHI while in transmission to the individual, based on the individual's request. Further, covered entities are not responsible for safeguarding information once delivered to the individual" (U.S. Department of Health and Human Services, 2013).

I understand & agree to each of the following statements regarding telehealth:
I understand the risks of receiving an email for my appointment through Zoom and/or KASA (medical records system) and I still prefer to receive these.

Initials _____ _____ _____ _____ _____ _____

I understand the risks of receiving communicating with my therapist about appointment times via email and I still prefer to receive these.

***If you are opting out of email communication with your Student Therapist and/or Clinic Staff, please indicate this here*_____**

I understand that all electronic communication is a part of my legal-medical record.

I understand that I have to be physically located in the State of Iowa at the time of my session. If I am in another state, I understand I must reschedule the session.

I understand I am not to be in the act of driving. If I am, I understand the session will be rescheduled.

I understand that in very rare instances, security protocols could fail, causing a breach of privacy of personal therapeutic information.

I also understand that the Olson MFT Clinic utilizes the below suicidality protocol while doing telehealth sessions:

- I understand I will be asked every session before starting the session if I have any suicidal thoughts, ideation, plan or intention.
- If my Student Therapist deems that I am a risk to myself, I will be required to call Foundation 2 crisis line (319-362-2174) so that I can be fully assessed for safety.
- I understand I cannot continue sessions without confirmation of safety.
- I understand if I tell my therapist I have intentions or plans to kill or hurt myself or others, my therapist will call mobile crisis, 911 and/or police.

By agreeing to Telehealth (video) session via HIPAA compliant Zoom, you agree to assume the risk of limited confidentiality of the session content and personal protected health information.

PHONE

Phone sessions are ***not*** HIPAA compliant due to the nature of phones. Your Student Therapist will do everything they can to maintain your confidentiality in a phone session but cannot promise confidentiality

By agreeing to sessions via phone, you agree to assume the risk of limited confidentiality of the session content and personal protected health information.

Initials _____ _____ _____ _____ _____ _____

NON-RECORDING AGREEMENT

Successful therapy depends on building a relationship of trust, good faith, and openness between client(s) and therapist(s). Often, audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all the other persons in the room.

In addition, recordings made and taken home by clients sometimes fall into unintended hands through loss, random or targeted theft, or action by police, court or governmental agency. Such loss could compromise or nullify your legal expectation of confidentiality in the extremely sensitive personal or interpersonal matters that may have been discussed. Courts may not give your own recordings all the legal confidentiality they give to a therapist's office notes and may find them self-serving. Client recordings can more easily end up becoming an issue in conflicts such as divorce, child custody, or other legal cases or be used by agencies of government. A client who makes a recording solely for personal use or to use against a partner may later be surprised to find the recording being used against him- or herself instead. And once an unfavorable recording exists, its deletion can become legally punishable if a subpoena is issued for it. Additionally, most users of recording technology lack the technological tools and knowledge required to delete a recording in a way that makes it unrecoverable and unhackable.

Factors like these undermine the therapeutic process and the building or rebuilding of trust that takes place between partners in session and between the client(s) and therapist(s). For these reasons and others like them, the Olson Clinic maintains a strict policy on recording. Therapists at Olson Clinic will only consent to recording of a session for exceptional reasons and only after the drawbacks and risks have been discussed and the benefit clearly outweighs them.

Therefore, the client agrees that:

Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

Initials _____ _____ _____ _____ _____ _____

FEES

Fees for Service [Student Therapist will fill out]: $_____ /session

In-person, telehealth or phone session fee are billed at the same rate. Fees are determined on a sliding fee scale below and are due at the time of the session.

Sliding Fee Schedule – Based on 2021 Federal Poverty Guidelines					
Family Size	Minimum	25% Pay	50% Pay	75% Pay	100% Pay
Income Level	100%	133%	166%	200%	233%+
1	$12,880	$17,130	$21,381	$25,760	$30,010
2	$17,420	$23,169	$28,917	$34,840	$40,589
3	$21,960	$29,207	$36,454	$43,920	$51,167
4	$26,500	$35,245	$43,990	$53,000	$61,745
5	$31,040	$41,283	$51,526	$62,080	$72,323
6	$35,580	$47,321	$59,063	$71,160	$82,901
7	$40,120	$53,360	$66,599	$80,240	$93,480
8	$44,600	$59,318	$74,036	$89,200	$103,918
Fee	$10.00	$15.00	$20.00	$25.00	$30.00

CONSENT

By signing below, I agree to the guidelines outlined in regard to General Clinic Procedures, In-Person Sessions, Telehealth and Phone Guidelines. I agree to pay the fee assigned above. I agree that consent to services remains in effect as long as I attend the Gerald & Audrey Olson Marriage & Family Therapy Clinic and/or Mount Mercy University Counseling Center and can only be revoked by me in writing with such notice being provided to the clinic.

☐ I have read this form and I AGREE to receive counseling services.

☐ I have read this form and I DECLINE to receive counseling services.

_____Date

Signature of Client Who's Name is on File for this Session:

_____	_____	_____
Print Client Name/Legally Authorized Person	Signature	Relationship to Client

Signatures of Additional Client(s) Who are Joining For Therapy:

Print Client Name/Legally Authorized Person	Signature	Relationship to Client

Contact Information: email: _____ phone:_____

Print Client Name/Legally Authorized Person	Signature	Relationship to Client

Contact Information: email: _____ phone:_____

Print Client Name/Legally Authorized Person	Signature	Relationship to Client

Contact Information: email: _____ phone:_____

Print Client Name/Legally Authorized Person	Signature	Relationship to Client

Contact Information: email: _____ phone:_____

Print Client Name/Legally Authorized Person	Signature	Relationship to Client

Contact Information: email: _____ phone:_____

APPENDIX E- MINOR CUSTODY FORMS

AGREEMENT REGARDING CHILD THERAPY SERVICES WITH THE OLSON MARRIAGE AND FAMILY THERAPY CLINIC

This document contains additional information about our services, specifically when working with minor children, families, and those families who are experiencing or have experienced a divorce/separation. If you have any question or concerns, please ask for clarification at any time.

Confidentiality
In general, the privacy of all communications between a client and a counselor is protected by law. When working with families, confidentiality if maintained within the family members attending therapy sessions. We use clinical discretion to determine what information is helpful to share in the therapy process. We want children to feel confident that what we talk about is confidential. We also know that parents need updates regarding progress, goals, and know that it is important for parents to be active participants in their child's treatment. In divorce situations, when appropriate, a signed release is required by both parents in order for us to release any information regarding the child and family to any person or entity. Please see the general office policies for further information regarding confidentiality.

By law, confidentiality must be breached if a Student Therapist suspects that any minor is being or has been abused, if a person plans to physically harm another person, or if a person plans to harm themselves. Additionally, breaching of confidentiality will occur if a Student Therapist suspects that an elder or dependent adult is being or has been abused.

Professional Records
Our policy is to encourage that any parent having rights to the child be involved in services to the degree that is appropriate or beneficial to the child. We make every attempt to contact any parent having rights to the child, so that they are able to give consent or dissent to treatment. For therapeutic reasons, it is our policy to request that parents allow their child privacy in treatment and ask that they reframe from seeking copies of their child's mental health file. This allows the child to take ownership of his or her work in therapy and prevents information from being used in a way that could be possibly detrimental or damaging to the child.

Court Testimony
As your child's mental health provider, it is our ethical duty to provide your child the best care possible. If asked to provide records or testimony about treatment to the court, this can contribute to a "dual-role" relationship between your child and their therapist. This relationship means that I your child's therapist is no longer in a therapeutic role with your child; rather, the therapist would serve as a "witness," and this could potentially damage your child's past, present, or future experience in therapy. Confidentiality and trust are paramount in therapy. In addition, we have an ethical responsibility to only release records to persons who are qualified and trained to interpret the information; once records are released in a court setting, we are unable to control who may have access to your child's and family's information. We assume that parents want to work toward the best interest of their child, which includes maintaining a safe and confidential therapeutic environment with their therapist.

With this in mind, we will not provide therapy records, notes, or testimony to the court as a part of litigation without a court order. Furthermore, Student Therapists at the Olson Clinic are not trained to testify in court disputes. For the reasons noted above, if any therapist at the Olson Clinic is required to provide testimony or records to the court under a court order, we reserve the right to terminate services and make an appropriate referral.

Custody and Visitation Issues
We do not provide custody evaluations. We cannot make recommendations about custody or visitation issues.

Informed Consent to Treatment

I have read the office policies provided to me, and agree to allow my child to participate in services. I further agree to the policies presented to me in this and other documents.

_____	_____
My child's name	Date of birth
_____	_____
Parent/legal guardian signature	Date
_____	_____
Parent/legal guardian signature	Date

JOINT CUSTODY PARENT CONTACT FORM

At The Olson Marriage and Family Therapy Clinic, unless Sole Physical Custody can be verified by a custody agreement, both parents need to consent for treatment of a minor. Please provide us with the information to contact the other parent. We will be calling them and/or sending them a letter offering them the opportunity to deny consent. If they do not reply, services will continue.

Parent Name: _____

Address: _____

_____

Phone: _____

Have you discussed therapy services with them? Yes: _____ No: _____

Are there any concerns that we should be aware of:

_____

_____

_____

_____

Thank you,

_____

JOINT CUSTODY CONSENT FORM

Dear _____,

The purpose of this letter is to inform you that your child, _____, is receiving mental health services at The Olson Marriage and Family Therapy Clinic. If you have questions or concerns about these services, please contact their therapist, _____, at (319)368-6493. Parents with joint legal custody have equal rights in consenting to medical/therapeutic treatment for their child, unless otherwise noted in a custody or divorce decree. If you do NOT wish for your child to be receiving therapy, please sign and return the bottom of this letter within 14 business days to 1650 Matterhorn Drive NE, Cedar Rapids, IA 52402. If we do not receive this, we will assume that you consent to treatment.

Thank you,

_____

Return form to:
The Olson Marriage and Family Therapy Clinic
1650 Matterhorn Drive NE
Cedar Rapids, IA 52402, 52402

I, _____, the parent of _____, wish to inform you that I do NOT consent to mental health services by The Olson Marriage and Family Therapy Clinic. Please discontinue treatment.

_____ _____
Signature Date

ROI WITH MULTIPLE SIGNATURE LINES FOR PARENT/GUARDIAN RELEASE

I, _____, hereby authorize the Gerald and Audrey Olson Marriage and Family Therapy Clinic (hereinafter referred to as the Olson MFT Clinic) to release verbal and/or written information to:

_____ _____ _____

Full name of person or entity | Phone | Fax

_____

Address

For the following purposes:

□ Treatment and assessment □ Coordination of care □ Referral of new or additional services

□Other_____

Specific information to be released includes:

□ Assessment and diagnosis □ Treatment goals □ Session Content □ Discharge

□ Other: _____

I understand that by signing this General Authorization I am authorizing the Olson MFT Clinic to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to the Olson MFT Clinic.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to the Olson MFT Clinic. I understand that my revocation of this General Authorization will not affect a disclosure that the Olson MFT Clinic has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Olson MFT Clinic's confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

I understand that signing this is not a condition of receiving services.

This authorization will expire 12 months from the date it was signed or on the specified date of ____/____/_____.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(INITIAL ANY CATEGORY NOT TO BE RELEASED)

_____Mental Health _____Substance Abuse _____HIV/AIDS _____ Genetic information including genetic test results

_____ _____ _____

Printed name Client and/or Client's Parent or Legal Guardian | Signature | Date

_____ _____ _____

Printed name Client and/or Client's Parent or Legal Guardian | Signature | Date

_____ _____ _____

Printed name Client and/or Client's Parent or Legal Guardian | Signature | Date

CHILD DEMOGRAPHIC FORM: COMPLETED BY PARENT/GUARDIAN

Name: _____

Name of child: _____

Age of child: _____

My relationship to the child is: _____

Who has legal custody of the child? _____

My child identifies their gender as: _____

My child identifies their race and/or ethnicity as: _____

My child's religious affiliation is (if any):_____

What grade is your child in? _____

Number of individuals in my household is:_____.

My household income is: _____

On average, I work about _____ hours per week.

What is your relationship status?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Cohabitating/Live with
- ☐ Other _____

Please mark if applicable:

- ☐ I am a veteran / a family member of a veteran.
- ☐ I am a Mount Mercy University faculty, staff, student and/or a family member of a Mount Mercy University faculty or staff member

How did you hear about the Olson Clinic?

The Olson Marriage & Family Therapy Clinic

Current Symptom Checklist

MY CHILD IS FEELING…	Never	Rarely	Sometimes	Frequently	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement of Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about the future					
Excessive feelings of guilt					
Low self-esteem					

MY CHILD IS EXPERIENCING…	Never	Rarely	Sometimes	Frequently	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
“Flashbacks” as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about a traumatic experience					

I NOTICE MY CHILD…	Never	Rarely	Sometimes	Frequently	For how long?
Is Angry, Irritable, Hostile					
Is euphoric, energized and highly optimistic					
Has racing thoughts					
Is needing less sleep than usual					
Is more talkative					
Mood fluctuates: go up and down					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Risk-taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

MY CHILD'S EATING INVOLVES…	Never	Rarely	Sometimes	Frequently	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss					
A lot of weight gain					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Concern about my sexual function					
Discomfort engaging in my sexual activity					
Questions about my sexual orientation					

EMPLOYMENT & SELF CARE	Never	Rarely	Sometimes	Frequently	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

Psychiatric History

Prior outpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior inpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior and/or current medication use? YES NO

Medication	Dosage	Frequency	Start Date	End Date	Physician

Has any family member had mental or emotional problems that warrant treatment? YES NO
yes, who / what / why (list all):

_____

_____

List family members

Name	Age	Gender	Relationship to Client

Describe any past or current significant issues in intimate relationships or immediate family relationships:

Medical History

Describe current physical health ☐ Good ☐ Fair ☐ Poor

Comments:

List any non-psychiatric medications and supplements currently being taken (give dosage and reason ☐ Not applicable

List any known allergies ☐ Not applicable

Substance and Alcohol Use History

I USE THE FOLLOWING…	Never	Rarely	Sometimes	Frequently	For how long?
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

Client Treatment History

- ☐ Outpatient (age[s]) _____
- ☐ Inpatient (age[s]) _____
- ☐ 12-step program (age[s]) ____
- ☐ Stopped on own (age[s]) _____
- ☐ Other (age[s]) _____

Family alcohol/drug abuse history

- ☐ father
- ☐ mother
- ☐ grandparent(s)
- ☐ Sibling(s)
- ☐ other_____
- ☐ stepparent/live-in
- ☐ uncle(s) and/or aunt(s)
- ☐ /significant other
- ☐ children

Uses of Substance and/or Alcohol Use

- ☐ hangovers
- ☐ seizures
- ☐ blackouts
- ☐ Accidental overdose
- ☐ Binges
- ☐ Arrest(s)
- ☐ Withdrawal symptoms
- ☐ Medical Conditions
- ☐ Increase of Tolerance
- ☐ Loss of Control over amount used
- ☐ Job Loss
- ☐ Other_____
- ☐ Sleep disturbances
- ☐ Assault (s)
- ☐ Suicide Attempt(s)
- ☐ Suicide Impulse/Thoughts
- ☐ Sleep disturbances

Socio-Economic Status History

Living Situation

- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

Social support system

- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ distant from family of origin

Financial situation

- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

Employment

- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ unemployed
- ☐ coworker conflicts
- ☐ Supervisor conflicts
- ☐ unstable work history
- ☐ disabled:_____

Legal history

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison _____ time(s), total time served: _____

Relationship and Family History

Relational status

- ☐ Single
- ☐ Married
- ☐ Separated/Divorced
- ☐ Cohabitating
- ☐ Other _____

Intimate relationship

- ☐ never been in a serious relationship
- ☐ not currently in relationship
- ☐ currently in a serious relationship

Relationship satisfaction

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied with relationshi
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

List family members

Name	**Age**	**Gender**	**Relationship to Client**

Describe any past or current significant issues in intimate relationships or immediate family relationships:

_____

_____

_____

MEDICAL HISTORY

Describe current physical health ☐ Good ☐ Fair ☐ Poor

Comments:

_____

_____

_____

List any non-psychiatric medications and supplements currently being taken (give dosage and reason ☐ **Not applicable**

_____

_____

_____

List any known allergies ☐ **Not applicable**

_____

_____

_____

APPENDIX K – GOOD FAITH ESTIMATE

GOOD FAITH ESTIMATE

At The Gerald & Audrey Olson Marriage & Family Therapy Clinic (Olson Clinic) therapy is conducted by students under the supervision of Licensed Marriage and Family Therapists and AAMFT-approved supervisors/supervisor candidates.

Student Clinician Name: _____

Supervisor Name	***License Number***	***NPI Number***
Dr. Heather Morgan-Sowada	000388	1427449503
Dr. Anthony Mielke	093697	1578082848
Dr. Douglas McPhee	110008	1023638673

Olson Clinic Phone: 319-368-6493
Olson Clinic Address: 1650 Matterhorn Dr. NE, Cedar Rapids, IA 52402
Tax ID: 420681046

Patient Name:	
Patient Address:	
Patient Phone #:	Patient Email:
Patient Diagnosis (if known/applicable):	
Services Requested:	

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of

services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The fee for a 45-minute psychotherapy visit (in-person or via telehealth) is $_____. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based upon a fee of $_____ per visit, if you attend one psychotherapy visit per week, your estimated charge would be $_____for four visits provided over the course of one month; $_____for eight visits over two months; or $_____for 12 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate _____

SCREENER FOR CHILD: COMPLETED WITH PARENT/GUARDIAN

Client Name:

_____

Parent/Guardian Name: _____

Student Therapist Name: _____

Student therapists must use this form to screen for any conditions that might rule out their child client and associated family system from receiving services at the Olson MFT Clinic. Students must complete this form during the course of the intake procedure and upload a copy to the client's file. Based off clinical judgment and supervisor recommendation, the screening could take place with parents together (but child should not be in the room), or the screener could be conducted with each parent individually.

Clients who exceed the cutoff scores must be informed that the student therapist is required to consult with their supervisor to ensure appropriateness, and that the client will be informed if a referral needs to be made. *However, student therapists should still schedule a second appointment with the child/family, especially if they feel that the client is appropriate for services even though they exceeded the cutoff. The completed form should be uploaded to the client file.*

Drug and Alcohol and Drug Screening

Please read the following questions out loud and record the parent(s)' answers. Questions 1, 2, and 4 do not need to be asked if the client is a young child.

1. Has your child ever tried alcohol or a non-prescription drug? YES NO
2. Has anyone in your child's life pressured you child to try alcohol and/or a drug? YES NO
3. Does a family member drink alcohol and/or use drugs when your child is around them? YES NO
4. Do your child's friends drink alcohol or use drugs when your child is around them? YES NO

Consult your clinical Supervisor if the identified patient's parent(s)/guardian(s) answer "yes" to any of the questions listed above.

Bully and Violence Measures

This measure is to be administered with the identified patient's parent(s) or guardian(s)

Please read each of the following items and have the individual answer "yes" or "no".

1.	Do you have concerns about your child being bullied?	YES	NO
2.	Do you have concerns about your child being a bully?	YES	NO
3.	**Has anyone every hit, slapped, or punched your child?**	**YES**	**NO**
4.	Have you ever hit, slapped, or punched your child?	YES	NO
5.	**Has anyone every touched your child in a way that made them feel scared or uncomfortable?**	**YES**	**NO**
6.	**Have you ever touched your child in a way that made them feel scared or uncomfortable?**	**YES**	**NO**

If a parent/guardian answers "yes" to any of the questions in bold you must seek supervision from your practicum Supervisor.

Mental Health Screening

Has your child ever been diagnosed with a severe mental illness. What was this diagnosis?

Record response here: _____

Please note that it is traditionally inappropriate to diagnose a child or teen with severe mental illness such as schizophrenia, psychotic disorders, bipolar, schizoaffective disorders, or personality disorders. If a parent/guardian reports that the child has received a severe mental illness diagnosis, please discuss this diagnosis with your practicum Supervisor.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past 3 months**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

******THESE QUESTIONS ARE ASKED WITH REGARD TO THE CHILD. YOU CAN SCREEN THE PARENT(S)/GUARDIAN(S) FOR SUICIDE IF YOU FEEL IT IS INDICATED******