Vermont Center for Children, Youth, and Families
University of Vermont Medical Center
1 South Prospect St; Burlington, VT 05401

Name of Patient/Client

Date of Birth

PATIENT'S/CLIENT'S INFORMED CONSENT

1. I have chosen to seek evaluation and/or treatment at the University of Vermont Medical Center for myself, or my child. My choice has been voluntary and I understand that I may terminate treatment at any time.

2. I acknowledge that no guarantees have been made to me as to the results of evaluation or treatment.

3. I understand that in the interest of providing the best quality of care for me, and/or my child, the clinician(s) will periodically seek consultation with professional colleagues who practice the same discipline. I understand that during these consultations my clinician(s) will not identify me, or my child, by name and will preserve my, and/or my child's anonymity by disguising other identifying material.

4. I understand that the consultant(s) with whom my clinician(s) discusses my treatment are bound by laws of confidentiality not to disclose information about me, my child, or treatment.

5. I understand that I may seek treatment with other mental health professionals who are not required to seek consultation about my treatment.

6. I understand that my clinician(s) will record each visit in my, or my child's, clinical records. This information will include the date(s) of the visit(s), the time spent, the diagnosis (except as prohibited by state and local laws), and any information that is deemed clinically important.

7. I understand that I have a right to discuss with my clinician(s) what information goes into my, or my child's, medical record.

8. I understand that my, or my child's, records will be released only in accordance with state laws requiring confidentiality of such records.

9. I understand that periodically Patient Financial Services may require a copy of my, or my child's, records in order to process insurance claims.

10. I understand that some insurance reimbursements depend on network affiliation and my choice of provider may affect insurance eligibility.

11. I understand that the Center is a teaching unit of the Department of Psychiatry, University of Vermont College of Medicine. Patient/client records may, therefore, be reviewed by medical students and other trainees under qualified supervision, and in accordance with state laws requiring confidentiality of such records.

PATIENT/CLIENT'S INFORMED CONSENT - CONTINUED

12. I also understand that the Center is a research unit of the Department of Psychiatry, University of Vermont College of Medicine. Data from the records with the department are sometimes used in anonymous form for statistical and research purposes, in accordance with federal regulations governing research with human subjects. In addition, I understand that I may be offered opportunities to participate in research projects conducted by Center staff, but that I am under no obligation to participate, nor will it impact on my, or my child's treatment if I choose not to participate.

13. I understand that there may be circumstances in which the law requires my, or my child's, therapist to disclose confidential information. These circumstances include:

a. abuse or neglect of minors or the elderly;
b. situations in which there may exist and danger to me, my child, or others.

14. I understand that this evaluation/treatment is not intended for legal proceedings, and I will notify my, or my child's, clinician if my intent is for court involvement. I understand that I may be asked to sign an agreement, with all related parties, verifying that the evaluation/treatment will not be used in court proceedings, no will the clinician(s) be asked to testify.

15. I understand that I may also incur other charges if I direct my clinician to prepare special reports of letters on my, or my child's, behalf. Any associated charges will be explained to me in advance so that I may make an informed decision about proceeding with the service.

16. I understand that I will be charged for missing scheduled appointments or late cancellations less than 24 hours. Alternatively, if I miss appointment I may be placed on a different scheduling track. Details will be provided at the time that such a measure would need to be implemented.

17. This agreement is in effect throughout the duration of the treatment relationship.

I HAVE READ THIS FORM AND CERTIFY THAT I UNDERSTAND ITS CONTENTS.

Signature of patient/client, parent or guardian | Relationship to Patient/Client | Date

Signature of clinician(s) | Date