



**CONSENT FOR UTILIZATION OF SERVICES**

I, \_\_\_\_\_, VOLUNTARILY GIVE  
Printed Patient Name

CONSENT to receive interprofessional services from the CARE Center.

I understand that my treatment team providers; Don Scott, MD., Lisa Renzi-Hammond, PhD., Jenay Beer, PhD., Lawrence Sweet, Stephen Correia, PhD., Sarah Saint Hamilton, PhD, MSW, Devin Lavender, PharmD., and other CARE Center providers are required to follow the same confidentiality standards as other professionals in their field.

**LIMITS TO CONFIDENTIALITY:** I understand there are primarily four conditions under which the provider may breach confidentiality:

- Belief that I am at risk for doing harm to myself.
- Belief that I am at risk for doing harm to others, such as committing a serious legal offense.
- Belief that a child under the age of 18, an elderly individual, or someone who is cognitively disabled has been physically or sexually abused or neglected.
- In the case that a subpoena is ordered by a judge in a court of law.

Such disclosures will be made to the appropriate authority, including, if necessary, emergency services, Department of Family and Children's Services or Adult Protective Services, and/or the Institute providing the subpoena. The shared information will be limited to material directly pertinent to the reduction of that danger. We cannot guarantee the confidentiality of records once they are released.

**MAINTENANCE OF RECORDS:** I understand that my records will be maintained in a manner that meets the standards of the CARE Center and state law. Records will be maintained electronically in our secure database. Any hard-copy or paper records will be kept and maintained in locked files for 10 years from your last attended appointment. You have the right to access your records. If you wish to access them, or have questions about how to do so, please ask your provider(s).

**APPOINTMENT LENGTH AND FREQUENCY:** Appointments may vary in length depending on the type of assessment; medical exams usually take 60 minutes, while neurocognitive assessments can take up to 90 minutes. Standard of care for diagnosis includes a visit with our geriatric physician, a full neurocognitive assessment, and a follow-up visit with our team. The frequency of your appointments will be determined in consultation with your CARE provider(s). **NOTE: Providers are not available outside scheduled visit times. In case of an emergency, call 911.** For non-emergencies please reach out via phone or email.



- MISSED APPOINTMENTS:** I understand a missed appointment hinders my progress and limits service availability to other clients. There may be times when I or my clinician may have an emergency or be unable to start on time. I will contact the CARE Center as soon as possible if I must cancel or will be late for a session. I understand if I am late, it may not be possible to meet for the full session. **Counseling/therapeutic services:** I also understand that if I cancel or no-show for 2 consecutive counseling appointments, my case may be closed until a new referral is made, as therapeutic progress depends on my ability to attend my sessions.
- EXTERNAL REFERRALS:** In some cases, referrals for consultation with other professionals may be made if my provider(s) believes additional help is needed for my treatment to be successful. I will be notified of any outside referrals and will be asked to sign a medical release form. My provider(s) may also initiate a process of terminating treatment if they believe that I would be better served by another professional or if they believe that it is in my best interests to conclude treatment.
- STUDENT CLINICIANS:** I understand that some of the CARE center providers are PhD students who are completing training related to their program (e.g., Clinical Psychology).
- I understand that these students are required to follow the same confidentiality standards as their licensed supervisors, and every provider at the CARE Center.
  - I understand that working with a provider(s) in training may require that some of my sessions may be video and/or audio recorded for educational and clinical supervision purposes. I will be notified if a session is being recorded. The footage and content of my sessions will be maintained in strictest confidentiality and viewed only by the necessary supervising professional(s) for the instruction and education of my clinician in training. All recordings will be erased one year after the date of the recording.
- NECESSITY OF COOPERATIVE EFFORT:** I understand that medical/neuropsychological assessment and therapeutic services require an active and cooperative effort from both patient and provider. The provider(s) agrees to make a good faith effort. I further understand that the provider(s) will carry out their responsibilities in accordance with applicable state laws and ethical standards of their profession.
- ELECTRONIC COMMUNICATION AND PRIVACY:** I understand that all forms of electronic communication, including phone calls, email, texting, and faxing cannot be guaranteed private given the nature of electronic communications.



**Please initial next to each statement below:**

\_\_\_\_\_ I understand the limits to confidentiality as outlined above.

\_\_\_\_\_ I understand the contents of this document and give my consent for counseling services.

\_\_\_\_\_ I understand there is NO fee Involved for these services.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Name (Printed)**