Pediatric Specialists of Virginia

Children's National INOVA

CONSENT TO RECEIVE OUTPATIENT BEHAVIORAL HEALTH/PSYCHOLOGY SERVICES

Patient Name: _____ MR #: _____

I, _____, as the patient or parent/legal guardian of _____, hereby give my consent for myself or my minor child to receive outpatient behavioral health services at Pediatric Specialists of Virginia (PSV). Outpatient behavioral health (also referred to as psychology) services may include any combination of the following: consultation, individual therapy, parent-child therapy, and psychological screenings/evaluation. I understand that sessions are confidential and, if applicable, understand that by providing my child with privacy it creates safety that is paramount to the therapeutic relationship. I acknowledge and understand that clinical cases may be discussed with other staff members at PSV for supervisory, medical and/or consultation purposes.

I understand and acknowledge that there are limited and specific exceptions to confidentiality in which clinicians may be required to disclose otherwise confidential information, such as cases of suspected child abuse and/or neglect, or cases where a patient threatens imminent harm to self or others. I also acknowledge and understand that by proceeding with behavioral health appointments at PSV, I am aware that the psychologist and subsequent team are partners with my or my child's medical providers and documentation is made in the electronic medical record and accessible to those providers working directly with me or my child/teen (including the larger Inova Health Systems and participants in Care Everywhere). _____(initials)

I understand and acknowledge that PSV Psychology does not have an emergency or after-hours service line for psychology specific emergencies. I understand and agree that if a behavioral or psychiatric emergency arises, and I am unable to reach my or my child's clinician during normal business hours, I should call 911, or take myself or my child to a local emergency room to be evaluated by a behavioral health specialist in the emergency department. _____(initials)

I am aware that email with the psychology provider is used solely for the purpose of communicating information related to scheduling and is not for sharing clinical information, treatment summaries or emergency purposes. I also am aware that email is not considered a secure form of communication and MyChart portal is the most secure way to communicate confidential health related information. I agree to keep my language and communication through these avenues respectful and will not demean, discriminate, harass, bully, or threaten others. _____(initials)

I am aware that there are risks and benefits to behavior health consultation and psychological treatment. Some of these risks may include my child or myself feeling uncomfortable around specific topics of conversation, or that therapy will result in increased distressed feelings or behaviors in the patient before things improve. Another risk to behavior health consultation/treatment is that I may receive information regarding clinical concerns about myself or my child that may be distressing. Another risk of behavioral health consultation/treatment for minors involves possible disagreement among parents, disagreement between one or both parents and the minor, and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, the psychologist will listen carefully to

understand each parent's perspective and fully explain treatment recommendations while working to resolve the conflict.

I will communicate with the psychology provider if any concerns arise, so that the psychology provider can address these concerns. I am also aware that if at any time I do not feel that the treatment or the connection to the psychology provider is a good fit that I may withdraw myself or my child from psychology services. I am also aware that there are limited psychology providers at PSV and requests for another PSV psychology provider may not be accommodated. In that event, referrals will be provided for options outside of PSV. _____(initials)

I am aware that if I have joint legal custody/decision making for my child's mental health care, I am responsible for communicating with the child's co-parent and informing that parent of the date/time of the appointment. I am also responsible for providing the most recent custody order to PSV within two weeks from the date of the initial consultation. I am aware that the psychology provider may also request information about the child's co-parent to obtain consents from all parties when needed. I understand that if I do not provide this information, withhold information related to custody and/or a co-parent, or delay sending the information beyond two weeks of the initial appointment, then this may result in the psychology provider terminating the treatment for my child. I am aware that minors in the state of Virginia have some rights when it comes to their treatment and that a minor child may request treatment without the consent of a parent in some circumstances. I also acknowledge that, in certain limited circumstances, a parent's access to their child's medical records may be limited. _____(initials)

I understand that PSV psychology department offers consultation for patients referred directly from their PSV medical provider, and I have the option to opt out of this service for myself or my child. I also am aware that the psychology department offers clinical training for doctoral psychology students, and that I have the option to opt out of treatment from a psychology extern at any time. _____(initials)

I understand that it is my responsibility:

1. To attend sessions on a timely and regular basis as determined by the psychology provider
2. To call in advance if I need to cancel an appointment. Failure to appear for two or more appointments without at least 24-hour notification, within a three-month time period, may result in discontinuation of psychology treatment and referrals will be provided.

I have read and understand the above. I consent to participate in the evaluation and treatment offered to myself or my child. I understand that I may stop treatment at any time.

Signature of Parent/Legal Guardian or patient if 18 years or older _____
Date_____