Patient Number: _____

Consent to Assessment

Effective July 1, 2013

Your Rights

1. Complaints. Integritas Psychological Services, Inc. (IPS) will carefully consider your complaints. The majority of patient complaints can be resolved with good will and open communication.

2. Civil Rights. Your civil rights are protected by federal and state laws.

3. Cultural and Spiritual Issues. IPS harmonizes its practice of psychology with a Catholic understanding of philosophy, anthropology, and theology. We believe respect for individual conscience and the patient's personal search for truth, goodness, beauty, and meaning are of the highest importance and we does not impose beliefs on our patients. Thus, patients do not have to be Catholic or subscribe to the teachings of the Catholic Church to receive treatment. You may request services from someone with training or experiences from a specific cultural or spiritual orientation. If we cannot provide these services, we will help you in the referral process.

4. Denial of Services. You may refuse services offered to you and be informed of any potential consequences.

5. Record Restrictions. You may request restrictions on the use of your protected health information; however, IPS is not required to agree with the request.

6. Availability of Records. You have the right to obtain a copy and/or inspect your protected health information. In rare cases, however, IPS may deny access to certain records. If IPS chooses to do so, we will discuss this decision with you.

7. Amendment of Records. You have the right to request an amendment in your records. This request, however, could be denied. If denied, your request will be kept in the records.

8. Medical/Legal/Spiritual Advice. You may discuss your treatment with your physician, attorney, clergy, spiritual director, and others.

9. Disclosures. You have the right to receive an accounting of disclosures of your protected health information which you have not authorized.

Your Rights to Receive Information

1. Costs of Services. The costs of services will be discussed with you before charges are incurred. (form: Payment Contract)

2. Termination of Services. You will be informed as to what behaviors or violations could lead to termination of services at IPS.

3. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used. (form: Privacy of Information Practices)

4. Policy Changes. You will be notified of policy changes in writing.

Our Ethical Obligations

1. IPS dedicates itself to serving the best interest of each patient.

2. We will not discriminate between patients based on age, race, creed, disabilities, or handicaps.

3. We maintain a professional relationship and hold professional boundaries with each patient.

4. We will end services or refer patients to other programs when appropriate.

5. Dr. Gudan will evaluate his personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. He will continually attain further education and training.

Your Responsibilities

1. You are responsible for your financial obligations to the clinic as outlined in the Payment Contract.

2. You are responsible to treat Dr. Gudan and fellow patients in a manner in which their rights are not violated.

If you believe your rights have been violated please discuss this with Dr. Gudan. If this does not resolve the issue, you may contact the Indiana State Board of Psychology for information on lodging a formal complaint.

I, _____, the undersigned, hereby attest I have voluntarily entered into assessment, or give my consent for the minor or person under my legal guardianship mentioned above to receive treatment, by Eric Gudan, Psy.D, HSPP, the licensed clinical psychologist at Integritas Psychological Services, Inc. I understand I am consenting and agreeing only to those mental health services Dr. Gudan is qualified to provide within the scope of his license as a Clinical Psychologist and Health Service Provider in Psychology in the State of Indiana. I further understand and agree Dr. Gudan may employ a psychological testing assistant under his supervision who will assist him in the process of psychological evaluation.

I understand the rights, risks, and benefits associated with treatment which have been explained to me. I understand I may discontinue treatment at any time.

I consent to psychological treatment and agree to abide by the above stated policies and agreements with Dr. Gudan and Integritas Psychological Services, Inc. I understand I can receive a copy of this consent document for my own records upon request.

Patient name (please print): _____

Signature: _____ Date:

_____

Signed by: __ patient __ parent/guardian __ personal representative

Witness signature: _____