Informed Consent for Assessment and Treatment

Client Name: _____

Date of Birth: _____

Date: _____

Purpose of Assessment and Treatment

You are being offered psychological/medical assessment and treatment services to better understand your current concerns and to develop a plan to improve your health and well-being. Services may include diagnostic interviews, testing, counseling, therapy, neurofeedback, and/or other related interventions.

Nature of Services

• Assessments may include interviews, questionnaires, rating scales, laboratory/medical tests, or brain mapping (QEEG).
• Treatment may involve evidence-based approaches such as psychotherapy, behavioral therapy, neurofeedback, or integrative medical services.
• The specific services you receive will be based on your needs and mutually agreed upon with your provider.

Potential Benefits

• Better understanding of your current difficulties.
• Improved emotional, cognitive, and/or physical functioning.
• Development of coping skills and strategies.

Potential Risks

• Emotional discomfort during discussions of personal issues.
• Temporary increases in distress when addressing difficult topics.
• Possible side effects from interventions (e.g., fatigue after neurofeedback, emotional intensity after therapy).
• No guarantee of improvement.

Confidentiality

• Information shared is confidential and will not be disclosed without your written consent, except as required by law (e.g., risk of harm to self/others, child/elder abuse, court order).
• Records are securely stored in compliance with HIPAA and state regulations.

Voluntary Participation

• Participation is voluntary, and you may withdraw consent or discontinue services at any time without penalty.
• Declining or ending services may limit the ability to address your concerns fully.

Alternatives

• You may choose not to receive services here and may seek care from another licensed provider.

Fees and Payment

• Fees, billing, and insurance policies will be explained prior to treatment.
• You are responsible for all charges; we do not bill insurance and most services are not covered by insurance. You may request a "superbill."

Emergency Contact

• This practice is not a 24-hour crisis service.
• In an emergency, call 911 or go to the nearest emergency department.

Mandatory Reporting

Hawaii State Law

I acknowledge that Hawaii State Law requires (mandates) and designates all Physicians, Psychologists, Behavioral Health Counselors, Case Managers, Clinicians, Medical Assistants or Technicians, to report any suspected or reason to suspect cases of domestic violence and abuse to include all ages (child or adult) to the proper authorities as deemed necessary in behalf of the interested persons to protect their legal rights.

Consent

By signing below, you acknowledge that:
1. You have read and understood the information above.
2. You have had the opportunity to ask questions.
3. You voluntarily agree to participate in assessment and treatment.

Client/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____