



**Betty Shirley Clinic, University Medical Center  
Consent for Observation**

A primary mission of University Medical Center is the provision of competent patient care by medical students, residents, and graduate students. In order to maintain high-quality patient care and to serve the educational needs of The University of Alabama, these trainees are observed. We request your permission for the following:

**Teaching Clinics (Medical Students, Residents, Family Therapy Clinic):** The treatment team observes sessions behind the one-way mirror and/or closed circuit monitor. The teams includes faculty, medical students, residents, and therapist trainees.

**Therapist Trainees (e.g., Psychology, Social Work):** Therapist trainees usually conduct therapy sessions without observation. When supervisors do observe behind the one-way mirror or closed circuit monitor, you will be informed.

**Private Patients (non training setting):** Patients seen privately by the psychiatrists/psychologists/therapists are observed on an extremely rare basis and **your permission is required**. However, if you are seen in an emergency situation in teaching clinic or decide to be seen in teaching clinic for medication on a regular basis, or choose to work with therapist trainee, you are agreeing to the above.

I understand that such observations shall be maintained with confidentiality.

I understand that this consent may be withdrawn at any time verbally and or by giving written notice to the Clinic Director of the Betty Shirley Clinic. However, I understand and acknowledge that if I decide I do not wish to allow observation in the training situations, I will be unable to continue treatment in those settings.

I do hereby acknowledge that I have read this Consent in its entirety and that any questions I have regarding its contents have been explained to my satisfaction by a member of the staff at University Medical Center.

Signatures:

\_\_\_\_\_  
**Patient (or parent/legal guardian)**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Child (if over 14 years of age)**

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

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**UNIVERSITY MEDICAL CENTER**  
(Hereinafter referred to as UMC)

**PATIENT COMMUNICATION CONSENT FORM**

I agree to allow UMC to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize UMC to leave messages for me when I am unavailable.

PREFERRED CONTACT NUMBER	NUMBER/ADDRESS	MESSAGES (YES OR NO)
_____ Home Phone	(____) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Cell Phone	(____) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Work Phone	(____) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Text Messages	(____) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Patient Portal	<b>Registration required</b> (Ask nurse to register you for this free service). _____@_____._____	

**(Texting requires that you give us your cell number and for you to have a text enabled cell phone plan)**

**Email to be used for Patient Portal Registration Only**  
**Do not email patient except through Patient Portal.**

Security Questions: What is your mother's maiden name? \_\_\_\_\_  
 What is the name of your childhood best friend? \_\_\_\_\_  
 What is the brand of your first car? \_\_\_\_\_

I authorize UMC and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.

I understand that by leaving spaces blank I am indicating that I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFO
_____	_____	_____
_____	_____	_____

I authorize the following person(s) to pick up prescriptions. **(Please check the Controlled Substance Form)**

**EMERGENCY CONTACT ONLY -**

**NAME:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

By my signature below I acknowledge that I have read and understand the **Guidelines to Patient Communication** and information provided on this consent form. I understand the risk associated with the different methods of communication and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that UMC may impose.

\_\_\_\_\_  
Patient name printed Date

\_\_\_\_\_  
Patient/Authorized Signature Relationship to Patient

**UNIVERSITY MEDICAL CENTER**  
[hereinafter referred to as "UMC"]

Patient Name \_\_\_\_\_

Chart Number \_\_\_\_\_

**Acknowledgement of Notice of Health Information Practices**

We have made available to you our Notice of Health Information Practices. PLEASE REVIEW THIS NOTICE CAREFULLY! You may have a personal copy of the Notice, or you may access the Notice on-line at <http://umc.ua.edu/about/hipaa-notice/>.

The Notice explains when we might use/disclose your health information, and includes some of the following examples:

- when you give us permission to disclose your health information
- to aid in your treatment or to persons involved in your health care or the payment for such
- to help us or other health care providers get paid for services provided to you
- to improve our health care operations
- for use by businesses with whom we contract to help provide administrative support, but only if they agree in writing to keep your information private
- to public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Notice also explains some of your rights under HIPAA, including but not limited to your:

- right to ask that information about you not be disclosed to certain persons
- right to restrict disclosures of PHI to your health plan when you pay out of pocket in full for a healthcare item or procedure
- right to ask that we communicate differently with you to ensure your privacy
- right to look at and get a copy of most of your health information in our records
- right to request that we correct health information in your record that is wrong or misleading
- right to be notified when a breach of your health information has occurred
- right to have us tell you to whom we have disclosed your health information
- right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

**I acknowledge that I have been given an opportunity to review this facility's Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have.**

Signature of patient or patient's representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of patient's representative: \_\_\_\_\_

Relationship to the patient/description of authority to act for patient: \_\_\_\_\_

**FOR UMC USE ONLY:**Date Notice Made Available: \_\_\_\_\_ Notice Delivered: \_\_in person\_\_ mail\_\_ electronic Acknowledgement Signed? \_\_Yes\_\_ No  
Why Acknowledgement Not Signed: \_\_patient refused\_\_ patient failed to return\_\_ emergency\_\_ other \_\_\_\_\_

*Signed copy of Acknowledgement should be filed in Patient's Record*

## Betty Shirley Clinic Office Information And Policies

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**Information For Our Patients:** We ask that you read the following information regarding our practice and policies. If you have any questions, please ask our receptionist. When you have finished, please sign at the bottom.

**Staff:** Psychiatrists; Psychologist; Social Worker; Receptionist; Trainees: Family Practice Residents, Medical Students, Psychology Students and Social Worker Students.

**Appointments:** Our hours are 8:30am to 12:00 noon and 1:30pm to 4:45pm Monday through Friday; 5:00pm to 8:00pm on Tuesday (for established patients). All missed appointments not cancelled 24 hours in advance of the scheduled appointment will be billed to the patient (unless due to significant illness or an emergency). Since insurance does not cover these appointments, the patient is responsible for the whole fee. Effective January 1, 2007-Failure to come to your doctor's appointment three times within a six month period will result in your termination in this clinic and you will need to seek services elsewhere.

**Telephone Calls:** Calls are taken from 8:30am to 12:15pm and 1:30pm to 4:45pm; otherwise, phones are answered by the Center's operator or the answering service. Doctors will return calls after 4:00pm. Also prescriptions to be picked up or called in will be done after 4:00pm.

**Emergencies:** A psychiatrist is on call after hours for patients. Patients should call 205/345-1770 and tell the answering service they need to speak to the doctor on-call for Psychiatry. If they require in-person, after-hours assessment, they will usually be asked to go to DCH Emergency Department where an ER doctor or Family Practice Resident will see them, and consult with the psychiatrist on-call.

**Services:** Comprehensive outpatient assessment of adults, individual psychotherapy, family and marital treatment, child assessments, medication management, psychological testing, non-pharmacologic pain management, and group therapy. Supportive social services are also available. We do not provide inpatient service. When trainees provide services they are supervised by licensed faculty and all chart notes are read, edited and countersigned by the faculty. Whenever visits are to be audio-taped, videotaped or viewed through closed circuit monitor for teaching purposes, patients will be asked to sign a consent form acknowledging awareness of this procedure. The tapes are used strictly for providing teaching feedback to the trainees.

**Fees:** Patients are asked expected to pay their portion of the bill at the time of service. In case of disputes between the patient and a third party, the patient must pay the bill in full and settle the dispute with the third party. Psychological testing and laboratory services are billed as a separate charge from the visit.

**Record Keeping:** Charts are kept on our electronic medical record (EMR) system.

**Confidentiality:** To protect patient privacy, the EMR is only accessible to persons working in our Department and selected other individuals in Medical Records and the Business Office. Patient will be asked to sign HIPAA forms regarding to whom you give us permission to share information about you. Other than sharing information with other health care professionals involved in your care, and with persons whom you have given us permission to contact, we will not share information except court order or in the of the patient or someone else being in significant danger. For Children, elders, and compromised adults as victims, this includes physical, emotional and sexual abuse; for competent adults as victims; this includes duty to warn if a patient seriously threatens harm to another. (You should be aware that in cases of child custody disputes, psychiatric/psychological records are generally not protected). Patients 19 years and over are entitled to confidentially, as adults are, even with respect to their parents.

I have read and understand the above policies and agree to comply with them as they affect me.

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Signature of Patient (or Guardian)

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Date

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Witness

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Chart # \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State Zip

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX:  Male  Female Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Home Phone \_\_\_\_\_  Cell Phone \_\_\_\_\_  Work Phone \_\_\_\_\_

*(Please check which number would be preferred number for contact)*

Employer \_\_\_\_\_

Marital Status:  single  married  divorced  widowed RACE: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_

Spouse's Place of Employment \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**INSURANCE & RESPONSIBLE PARTY INFORMATION**  
 (This section must be filled out)

<p><b>Primary</b> _____</p> <p><b>Group #:</b> _____</p> <p><b>Policy #:</b> _____</p> <p><b>Responsible Party's Name (if other than patient)</b>                  _____</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><b>DOB:</b> ____/____/____ <b>Phone</b> _____</p> <p><b>Social Security #:</b> ____-____-____</p> <p><b>Address</b> _____  <small>Street</small></p> <p>_____  <small>City State Zip</small></p>	<p><b>Secondary</b> _____</p> <p><b>Group #:</b> _____</p> <p><b>Policy #:</b> _____</p> <p><b>Responsible Party's Name (if other than patient)</b>                  _____</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><b>DOB:</b> ____/____/____ <b>Phone</b> _____</p> <p><b>Social Security #:</b> ____-____-____</p> <p><b>Address</b> _____  <small>Street</small></p> <p>_____  <small>City State Zip</small></p>
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I authorize and request my insurance company to pay directly to University Medical Center any health benefits resulting from care received in that facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and I agree to assume responsibility for any services, procedures, devices, or testing not covered. I consent to the release to my insurance company of any medical record (except psychiatric) necessary to resolve claims for services rendered. I understand that co-pays and any services not covered by an insurance company are DUE IN FULL AT THE TIME OF SERVICE. Patient/guarantor understands that any credit balance *on a date of service* may be applied to other outstanding balances *due on other dates of services* for their personal account and/or for accounts for which they are the guarantor.

\*Signature \_\_\_\_\_ \*DATE \_\_\_\_\_

\*Relation to Patient \_\_\_\_\_

FOR OFFICE USE ONLY:

Suite \_\_\_\_\_ Doctor \_\_\_\_\_

New Patient \_\_\_\_\_ Update \_\_\_\_\_ OC \_\_\_\_\_ WC \_\_\_\_\_