MUSC
Medical University of South Carolina

CAPS Consent for Treatment

I, _____ (name of client) , voluntarily consent to psychological evaluation and psychotherapy through Counseling and Psychological Service (CAPS) at the Medical University of South Carolina.

I am aware that I may be asked to complete psychological questionnaires and/or tests as part of my evaluation and treatment through this clinic. I understand that the results of these questionnaires may also be used in scientific research and/or to insure the quality of services offered through CAPS. However, when used in this manner, my confidentiality is assured by the data being combined with that of other CAPS clients and all identifying information will be removed.

While in therapy, I have the right to ask for a referral and/or the right to terminate treatment at any point, if I choose to do so. I have the right to ask about alternate treatments for my condition. I recognize that my therapist has the right to terminate treatment or refer me for assistance elsewhere if she/he believes it would be in my best interest. I also understand that if I believe my therapist has engaged in illegal, unethical, or incompetent actions, I may contact the South Carolina Board of Examiners in Psychology, P. O. Box 11329, Columbia, SC 29211-1329, (803) 896-4664, or the South Carolina Board of Medical Examiners, P.O. Box 11289, Columbia, SC 29211-1289, (803) 896-4500, to make a written or verbal complaint.

I am aware that all information that I disclose and all written records are completely confidential and will remain accessible only to my therapist. As such, information (including files) about my case is not open and accessible to anyone without my consent. However, I understand that my therapist participates in supervision and may, at his/her discretion, choose to disclose some of this information for purposes of supervision. When it is indicated, my therapist may consult with the Student Health Services team regarding my treatment. While I have a full right to confidentiality, I also recognize that my therapist has a responsibility to breech confidentiality if any of the following conditions occur:

1) Child Abuse: When in a professional capacity, the CAPS staff has received information which gives us reason to believe that a child’s physical or mental health or welfare has been or may be adversely affected by abuse or neglect, we must report such to the country Department of Social Services or to a law enforcement agency in the county where the child resides or is found. If we have received information in our professional capacity which gives us reason to believe that a child’s physical or mental health or welfare has been or may be adversely affected by acts or omissions that would be child abuse of neglect if committed by a parent, guardian, or other person responsible for the child’s welfare, but we believe that the act or omission was committed by a person other than the parent, guardian, or other person responsible for the child’s welfare, we must make a report to the appropriate law enforcement agency.

2) Adult and Domestic Abuse: If CAPS staff has reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited, we must report the incident within 24 hours or the next business day to the Adult Protective Services Program. We may also report directly to law enforcement personnel.

3) Health Oversight: The South Carolina Board of Examiners in Psychology and Medical Board has the power, if necessary, to subpoena my records. CAPS personnel is then required to submit to them those records relevant to their inquiry.

4) Judicial or administrative proceedings: If I am involved in a court proceeding and a request is made about the professional services CAPS provided me or the records thereof, such information is privileged under state law, and CAPS will not release information without my written consent or a court order. The privilege does not apply when I am being evaluated for a third party or where the evaluation is court ordered. I will be informed in advance if this is the case.

5) Serious Threat to Health or Safety: If I communicate to the CAPS therapy/staff the intention to commit a crime or harm myself, CAPS may disclose confidential information when they judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by me on myself or another person. In this situation, CAPS must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.

6) Workers' Compensation: If I file a workers' compensation claim, CAPS is required by law to provide all existing information compiled by CAPS staff pertaining to the claim to your employer, the insurance carrier, their attorneys, the South Carolina Workers' Compensation Commission, or me.

7) If I am required by my Dean or Program Director to seek evaluation and/or treatment at CAPS for alcohol or other drug abuse, information regarding evaluation, treatment, recommendations, and attendance will be provided to the Dean or Program Director.My signature below indicates that I have read and understand the terms of treatment. I acknowledge that I have had ample opportunity to clarify any concerns I may have and agree to treatment under the above mentioned conditions.

Client's Signature_____ Date _____

Witness' Signature_____ Date _____

ACKNOWLEDGEMENT

I have received a copy of the Privacy Policy Notice for Counseling and Psychological Services (CAPS). I have also received a copy of the Notice of Privacy Practices for the Medical University of South Carolina.

Client's Signature_____ Date _____

Print Name _____

CAPS

Student Services (/students/caps/student-services)

Staff (/students/caps/staff)

Info (/students/caps/info)

Forms (/students/caps/forms)

ESL (/students/esl)

Contact CAPS

Phone: 843-792-4930
Fax: 843-792-2535

E-mail: caps@musc.edu (mailto:caps@musc.edu)