Fax: 469-587-8440 ***Location (check one):***

☐ INJURY 1 of DALLAS 9262 Forest Lane, Suite 101 Dallas, TX 75243	☐ INJURY 1 of FORT WORTH 3304 SE Loop 820, Ste A Fort Worth, TX 76140	☐ INJURY 1 of WACO 185 Eastgate Plaza Waco, TX 76705

INFORMED CONSENT FOR INITIAL BEHAVIORAL HEALTH EVALUATION

THE INJURY::1 MISSION: Our mission at INJURY::1 is to utilize an interdisciplinary treatment approach to meet the medical and behavioral health needs of individuals experiencing both physical pain (whether acute or chronic) and/or emotional pain, thereby increasing their independent functioning, decreasing their pain and associated distress, and coordinating a return to the highest quality of life which may be feasibly attained by the persons served.

INJURY::1 professionals are aware of the role that stressors can play in the lives of individuals, especially those with pain issues. Being off work and in pain can cause significant stress. Such stress may exacerbate and even trigger many physical symptoms. Pain is a significant stressor for the individual who is suffering. INJURY::1 strives to help individuals manage this experience.

INJURY::1 provides behavioral health services to the public. However, to do so effectively, it is important that an initial clinical interview be conducted to determine the extent and severity of an individual's situation. Services provided include: individual psychotherapy (counseling), psychological testing, biofeedback, and multidisciplinary return to work programs.

CONSENT FOR INITIAL ASSESSMENT: I agree to undergo an initial assessment and associated psychological testing at the direction of my doctor.

I understand and agree that the initial assessment and testing may include direct, face-to-face contact, interviewing, and paper-pencil testing.

I understand and agree that no INJURY::1 therapist-client relationship exists between the clinician and me, although one may be established in the future.

I understand that INJURY::1 clinician agrees to the following:

1) The procedures for selecting, giving, and scoring the tests, interpreting and scoring the results, and maintaining the client's privacy will be carried out in accordance with the rules and guidelines set forth by the Texas State Board of Examiners for Licensed Professional Counselors and other related organizations.
2) The tests and assessment methods to be used are suitable for me, the client.
3) The reliability and validity of these assessment methods have been established. The selected assessments will be given and scored according to the testing manuals so that valid scores will be obtained.
4) Test scores will be interpreted according to their manual, scientific findings, and guidelines from the scientific and professional literature.
5) All tests and test results will be kept in a safe and secure place.

DISCLOSURE OF INFORMATION: I understand and agree that my doctor will be given a report containing assessment results and interview information from INJURY::1.

I understand and agree that an agent of my insurance company or other third-party payer will be given a report containing assessment results and interview information from INJURY::1.

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I understand and agree that an agent of my insurance company, my legal representative, or other third-party payer will be provided information about the type(s), cost(s), date(s), and the providers of any testing or assessment I receive.

I understand and agree that if my doctor refers me for a psychotropic medication consultation and/or neurocognitive evaluation based on the assessment results, INJURY::1 may coordinate the referral as directed by my treating doctor, including releasing my clinical and medical records to the doctor and/or facility to which I am being referred for further assessment.

I understand and agree that I will not receive a copy of the evaluation report from INJURY::1 if it is suspected that the information obtained could prove harmful to me.

I understand and agree that I will not receive a copy of the assessment results and interview information from INJURY::1 unless reviewed between a clinician and myself, which would warrant scheduling an appointment.

I understand and agree that information about me, including case records, will be released under the following conditions in accordance with laws of the State of Texas:

a) The therapist is using case records for purposes of supervision, professional development, or training and research. In such cases, to preserve confidentially, clients will be identified by first names only;
b) The INJURY::1 clinical staff determines that the client is a danger to himself/herself or to someone else;
c) The client discloses current abuse, neglect, or exploitation of a child, elderly, or disabled person;
d) The client discloses sexual contact with another mental health professional with whom the client had/has a professional relationship;
e) The INJURY::1 staff member(s) is ordered by a court to disclose such information;
f) The client directs the therapist or INJURY::1 to release the client's records;
g) The therapist or INJURY::1 is otherwise required by law to disclose information.

I agree that a photocopy or fax transmission of this form is acceptable, but that it must be individually signed by me.

I understand that I have a right to receive a copy of this form upon my request.

With an understanding of the above information, I agree to participate in the clinical evaluation and related testing. I agree to release the counselor and INJURY::1 from liability for the same.

Client Signature	**Date**

I, the INJURY::1 representative, have discussed the issues above with the client. My observation of this person's behavior and responses gives me no reason to believe that this person is not fully competent to give informed and willing consent.

INJURY::1 Representative	**Date**

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