**CONFIDENTIAL** **CLIENT #_____**

THE UNIVERSITY of MISSISSIPPI

# PSC APPLICATION

Name: Date:
(Last) (First) (Middle)
Address:
(Street) (Apt) (City) (State) (Zip)
Can we send mail to this address? (circle one) **Yes** **No**

Home Phone: ( ) Okay to call? **Yes** **No** Okay to leave message? **Yes** **No**
Work Phone: ( ) Okay to call? **Yes** **No** Okay to leave message? **Yes** **No**
Cell Phone: ( ) Okay to call? **Yes** **No** Okay to leave message? **Yes** **No**
Email Address: Okay to send message? **Yes** **No**

Birth Date: Age: Gender: Sexual Orientation:
Social Security #: Religion: Ethnicity:
Occupation: Employer:
Relationship Status (circle): **Single** **In a Relationship** **Married** **Separated** **Divorced** **Widowed**
Education: Highest Grade Completed

How did you find out about us (please check one)?
□ Doctor Name □ Professor Name □ Google/Internet search
□ Friend/Family & Name □ Previous Client □ Other:
□ PSC Website □ UM Counseling Center & Name

Brief description of your reasons for therapy:

## Family Information

Spouse's/Partner's Name: Spouse's/Partner's Age:
Spouse's/Partner's Occupation: Spouse's/Partner's Highest Grade Completed:
Number of Children or Dependents:

| Children: Name | Age | Gender: | Living with you? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Father's Name: Mother's Name:
Father's Birth Date: Father's Age: Mother's Birth Date: Mother's Age:
Father's Highest Grade Completed: Mother's Highest Grade Completed:

## ***EMERGENCY CONTACT***

(Name) (Address) (Phone) (Relationship to You)

## Payment Information

Are you a student, faculty, staff, or a dependent of, at the University of Mississippi? **Yes** **No**
Total household **monthly** net income:

*****OFFICE USE ONLY*****
**Determined Fee:** **Client Initials:**

The Psychological Services Center provides therapy to you and your family at an affordable cost based on monthly income. We understand that there are a few cases in which a client is unable to make payment. If you feel that you are unable to afford the determined fee, please speak with your therapist or the Clinic Manager in order to make arrangements.

Full payment is due at the time of services unless other arrangements have been previously made. We accept **cash**, **check, or credit card (Visa, Mastercard)**. Although we do not make insurance claims directly, we can provide you with the receipt to send with the insurance claim.

**I understand and agree to the conditions and terms of payment at the Psychological Services Center.**

Signature: _____ Date: _____

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# INFORMATION ABOUT OBSERVATION AND RECORDING

**CONSENT TO OBSERVATION AND RECORDING BY PSYCHOLOGICAL SERVICES CENTER STAFF**

The Psychological Services Center (PSC) provides services to the community and functions as a training facility for doctoral students in the clinical psychology program at the University of Mississippi. All clinical services provided at the PSC are provided by clinicians in training, who are supervised by licensed psychologists. Because clinicians in training need to receive thorough supervision, it is necessary for sessions to be recorded. These recordings are used only for approved PSC training activities. In addition, the clinician in training may be observed by PSC staff (e.g., supervising psychologist or other members of the treatment team). Any information obtained through the use of this teaching procedure will be held in the strictest of confidence by the PSC staff.

If you have any problems or questions about any of these procedures and wish to discuss them with a staff member, please do so before signing below.

**I, the undersigned, have read and understand the above information concerning observation and recording, and give full and complete consent to allow recordings to be made of my (my child's) sessions. I further understand that these sessions may be observed by certified clinic staff members.**

Client Signature: _____ Date: _____

**The above name is a minor, and I as their parent or guardian, have read and understand the above information concerning observation and recording, and give full and complete consent to allow recordings to be made of my (my child's) sessions. I further understand that these sessions may be observed by certified clinic staff members.**

Parent/Guardian Signature: _____ Relationship: _____

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I, the undersigned, am an authorized representative of the Psychological Services Center and have witnessed the above signatures on the date they were provided.

Signed: _____ Date: _____