Evaluation and Treatment Agreement

This document contains important information about the professional services and business policies of Garret Zieve and Dr. Jacqueline B. Persons and the Oakland Cognitive Behavior Therapy Center. Please read it carefully and discuss any questions you have with Mr. Zieve or Dr. Persons.

UNIVERSITY OF CALIFORNIA, BERKELEY PSYCHOLOGY DEPARTMENT SUPERVISED TRAINING EXPERIENCE: Mr. Zieve is a graduate student in Clinical Psychology at the University of California, Berkeley. He is participating in a supervised training experience with Dr. Persons at the Oakland Cognitive Behavior Therapy Center in which Mr. Zieve will receive training in clinical work and research. As part of that training experience, Mr. Zieve will provide you with assessment and treatment, and will collect research data. Mr. Zieve will make video-recordings of your sessions that Dr. Persons will review as part of the training process. Dr. Persons will provide Mr. Zieve with extensive direct supervision and training. Dr. Persons will take legal and clinical responsibility for the care you receive from Mr. Zieve during this training experience.

ASSESSMENT AND TREATMENT: Mr. Zieve will provide an assessment of your difficulties and available treatment options. If he recommends and you agree, he will provide cognitive-behavior therapy, which has been shown in controlled outcome studies to provide effective treatment for a number of problems and disorders.

No guarantees can be made regarding the success of treatment. Treatment can be time-consuming and stressful. It can bring on strong feelings, such as anger or anxiety, and may result in changes that were not originally intended, such as divorce. For people in some professions (e.g., politics), the fact of being in treatment, if it becomes public, can negatively affect their career. There is a small risk that your condition will worsen due to treatment.

After meeting with you to assess your situation, Mr. Zieve will offer, if you would like, an estimate of the number of sessions of treatment he recommends for you. For most patients, this ranges between 5 and 40 sessions. Mr. Zieve's estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required. If treatment is needed beyond the tenure of Mr. Zieve's training experience, Mr. Zieve and Dr. Persons will help you find another clinician who can continue your care.

ALTERNATIVE TREATMENTS: Many options to the cognitive-behavioral treatment that Mr. Zieve can provide are available, including other types of psychotherapy, and medications. If Mr. Zieve recommends any of these in your case, he will let you know what his recommendation is and the reasons for it.

You are entitled to ask questions about all aspects of treatment. Mr. Zieve and Dr. Persons will help you secure a consultation with another mental health professional whenever you request it or she recommends it.

TRAINING AND EXPERIENCE: Mr. Zieve graduated from the University of Washington with a B.A. in Psychology in 2014. He is currently in his fourth year of the clinical psychology Ph.D. program at the University of California, Berkeley and has over three years of clinical experience. Mr. Zieve has seven years of research experience; his research interests are in patient memory and learning during treatment, the influence of therapist personality on treatment effectiveness, and tools to evaluate patient progress during treatment.

Dr. Persons is a psychologist licensed to practice in California. She graduated from the University of Pennsylvania with a Ph.D. in Clinical Psychology in 1979. She is Clinical Professor in the Department of Psychology at the University of California at Berkeley. She has been trained to provide and has more than 30 years of experience conducting cognitive-behavior therapy to treat depression, anxiety, and related problems in adults. She does not have extensive training or expertise in treating psychosis, substance dependence, couples, families, children, or adolescents.

THE PATIENT'S ROLE: You are expected to play an active role in your treatment, including working with Mr. Zieve to set treatment goals, completing questionnaires to assess treatment progress, and completing homework assignments between sessions. If at any point you are unhappy about any aspect of the therapy, please discuss this with Mr. Zieve so that you and he can work together to address anything you are unhappy about.

THE PATIENT'S RIGHTS: A document entitled Patient's Bill of Rights, adapted from a publication by the California Department of Consumer Affairs, is attached to the end of this document. Please read it carefully and raise any questions you have about it with Mr. Zieve.

HOURS/AVAILABILITY: Mr. Zieve will schedule sessions with you at times you and he mutually agree to. Therapy sessions are usually scheduled as 50-minute sessions weekly, or as your treatment needs dictate and you and Mr. Zieve agree. The best way to reach Mr. Zieve by telephone is at 206-607-7734. Dr. Persons is usually available in the office from 8 a.m. until 6 p.m. Monday through Friday. In the event of an emergency, Dr. Persons is generally available in her office during business hours (510-662-8405) and outside those hours by cell phone at 510-390-4721. In a crisis, you can call 911, or contact your primary care physician, the local emergency room, or crisis intervention services. When Mr. Zieve is out of town, he will let you know and will give you the name and telephone number of another therapist who will be available.

____ **(initial) CONFIDENTIALITY:** The confidentiality of communications between the patient and therapist is important and, in general, is legally protected. Dr. Persons will have access to all the information that you provide to Mr. Zieve. Both of these individuals will make every effort to keep the results of all your evaluation and treatment strictly confidential, as is required by law. Information about you will be released by Mr. Zieve or Dr. Persons only with your written permission, with the following exceptions:

- when there is suspected elder, dependent adult, or child abuse or neglect.
- when, in Mr. Zieve's or Dr. Persons' judgment, you are in danger of harming yourself or another person, or are unable to care for yourself.

- if you communicate to Mr. Zieve a serious threat of physical violence against another person; in this situation, Mr. Zieve is required by law to inform both potential victims and legal authorities.
- if Mr. Zieve or Dr. Persons is ordered by a court to release information as part of a legal proceeding.
- as otherwise required by law.

____ **(initial) E-MAIL AND TEXT COMMUNICATION:** You and Mr. Zieve may choose to communicate via e-mail or text. If you do, it is important to remember that if Mr. Zieve is obtaining information only in these ways, he is making clinical judgments on the basis of limited and imperfect information. Mr. Zieve may not receive e-mail in a timely fashion, so if your communication is urgent, it is best to use the telephone. If you choose to correspond with Mr. Zieve through e-mail or text, he will make every effort to keep the correspondence confidential, but he cannot guarantee confidentiality of these communications. E-mail, text, and voicemail communications are part of the medical record and are subject to discovery in legal proceedings. Please note that voice-mail messages that you leave for Mr. Zieve on his office telephone are transmitted to him via e-mail.

____ **(initial) USE OF ONLINE TOOLS AND MOBILE APPS:** Mr. Zieve may suggest that you use an online tool or a mobile application to record information related to your treatment, such as your mood and activities. He will make every effort to recommend tools and apps that are designed to maintain your confidentiality and to meet HIPAA security standards (e.g., encrypted data transmission). However, if you do use one of these tools, confidentiality cannot be guaranteed, and you agree to accept the risk that a breach of confidentiality may occur.

RECORD-KEEPING: Mr. Zieve will maintain a clinical record in which he will document your treatment, including a description of your condition, diagnosis, treatment goals, treatment plan, therapy session notes, information about fees and billing, and copies of consents, releases, assessments, and other forms related to your treatment. The various parts of the clinical record (billing, progress notes, assessments) may be stored separately. Clinical records are kept in a locked file cabinet in Dr. Persons' office, on a password protected USB drive at the University of California Berkeley, or and/or via an encrypted, secure, and HIPAA-compliant cloud-based service.

____ **(initial) CONSULTATION:** Mr. Zieve and Dr. Persons may wish to consult with other professionals, especially their colleagues at the University of California, Berkeley, about your case. Your signature at the end of this document gives Mr. Zieve and Dr. Persons permission to do this, provided that she takes reasonable efforts to protect your identity.

____ **(initial) RESEARCH, TRAINING, WRITING:** Mr. Zieve and Dr. Persons conduct research and training, and they write for professional and lay audiences. Your initials here give them permission to use information about you and your treatment in any of these ways, provided that they take reasonable efforts to protect your identity. If you do not initial, Mr. Zieve and Dr. Persons understand that they do not have your permission to use de-identified information about you in research, training, or writing. Declining to give permission will not affect your treatment with Mr. Zieve in any way.

DATA REPOSITORY: Mr. Zieve and Dr. Persons ask you here for permission to add data from your clinical record to a de-identified research database. *The research database will not include your name, address, or any other information that could identify you.* The database will be used for scientific research about the nature and causes of anxiety, depression, and other psychological difficulties; about the processes of change during treatment; and about the quality of our assessment tools, in order to improve our understanding of psychological difficulties and to improve our treatment of those difficulties. More information about the data repository is provided in the attached document titled *Data Repository Description*. You do not have to give permission for your data to be used in research unless you want to. Declining to give permission will not affect your treatment with Mr. Zieve and Dr. Persons in any way. Because no identifying information will be added to the data repository, data cannot be withdrawn from the data repository once they are placed there. **Your information will not be added to the data repository unless you initial below.**

____ **(initial)** I give permission for data from my clinical record that does not identify me to be entered into the data repository.

FOLLOW-UP ASSESSMENT: By initialing here, you give Mr. Zieve, Dr. Persons and the Oakland Cognitive Behavior Therapy Center permission to contact you after your treatment is over to collect information about how you are doing in order to help us improve our treatment procedures and for research purposes. Please initial any method of contact you agree to.

_____ email _____ telephone _____ mail

FEES: Mr. Zieve's fee is _____ per 50-minute session. Longer or shorter sessions are prorated from this fee. Of course, there will be no charge for brief telephone calls, such as those made to schedule appointments.

PAYMENT: Please pay Dr. Persons, and you can do this via check, bank transfer, or credit card. Payment is due at the time of the session unless another arrangement has been made. Dr. Persons will send you a monthly statement if you request one.

CANCELLATIONS AND MISSED APPOINTMENTS: If an appointment is missed or cancelled without 24 hours' notice, you may be charged for the session. Please be aware that insurance companies will not generally reimburse for a cancelled session.

INSURANCE REIMBURSEMENT: You are responsible for collecting reimbursement from your insurance company or other source. If you elect to seek reimbursement from an insurance company for your treatment, Dr. Persons will provide you with a monthly statement you can submit to your insurance company. Because Mr. Zieve is not licensed, your insurance company may not reimburse for his services. Most insurance companies require information about your diagnosis, the type of service provided (e.g., 50-minute individual psychotherapy session), the date of the session, and the fee, and Dr. Persons will include this information on your statement upon your request. Please be aware that when information is sent to an insurance company, Mr. Zieve has no control over who sees it.

FOR MEDICARE BENEFICIARIES ONLY:

If you are receiving insurance coverage through Medicare, please be aware that neither Mr. Zieve nor Dr. Persons are Medicare providers. Your signature below indicates that you accept full responsibility for payment of Mr. Zieve's fees. Additionally, your signature indicates that you will not submit claims to Medicare for Dr. Persons' fees or ask Dr. Persons to do so. Please note that Medicare limits do not apply to these fees, Medigap plans will not cover them, and other insurance plans may not cover them. You have the right to obtain services from providers who are covered by Medicare. If you see a provider who is covered by Medicare, you do not have to sign a private contract (like this one) with that provider.

_____ (Client signature) _____ (Therapist signature)

ENDING TREATMENT: You may withdraw from treatment at any time. Reasons you might want to end your treatment include that you have accomplished your goals, you are not making progress, or your working relationship with Mr. Zieve has deteriorated. If you are considering ending your treatment, Mr. Zieve recommends and would appreciate it very much if you would discuss this with him so he has an opportunity to offer his recommendations, including about changes in the treatment that could address your concerns, and to offer referral options if they are needed.

If Mr. Zieve experiences difficulties in working with you, such as if his working relationship with you deteriorates, therapy seems unhelpful, or you are unable to pay your bill, Mr. Zieve will discuss these difficulties with you and work with you to address them. If the difficulties cannot be resolved, Mr. Zieve will work with you to bring the treatment to an end. Mr. Zieve may end your treatment for any reason. He is ethically obligated to end the treatment if he believes he is not being helpful to you. If Mr. Zieve ends your treatment, he will offer, at minimum, a termination session to discuss his decision and to offer referrals to other potential providers.

If you discontinue meeting with Mr. Zieve for a period of four weeks or more, he will attempt to contact you. If he is unable to reach you, he will assume that you have decided to terminate your treatment and he will close your case. Of course, should you wish to resume your treatment at any time, he will be happy to discuss that option with you.

* * * * *

I have read and understood this agreement and the attached Patient Bill of Rights, and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment.

Name of patient (please print): _____

Signature of patient: _____

Date: _____

Patient Bill of Rights

You have the right to:

- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
- Receive respectful treatment that will be helpful to you.
- A safe environment, free from sexual, physical, and emotional abuse.
- Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request that the therapist inform you of your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment or end treatment without obligation or harassment.
- Refuse electronic recording (but you may request it if you wish).
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.
- Report unethical and illegal behavior by a therapist.
- Receive a second opinion at any time about your therapy or therapist's methods.
- Request the transfer of a copy of your file to any therapist or agency you choose.

Excerpted from "Professional Therapy Never Includes Sex," California Department of Consumer Affairs, 1997.

Description of the Oakland Cognitive Behavior Therapy Center Data Repository

REPOSITORY GUARDIAN: Jacqueline B. Persons, Ph.D., Director
Oakland Cognitive Behavior Therapy Center
5625 College Avenue, Suite 215, Oakland, CA 94618
www.oaklandcbt.com

PURPOSE

The purpose of this data repository is to support research that helps us improve our understanding and treatment of psychological difficulties. The term "data repository" refers to a database of de-identified information, that is, information that is not linked to the identity of the person who provided it. The purpose of this data repository is to collect and store information generated during your treatment at the Oakland Cognitive Behavior Therapy Center in order to support research studies. Typical research topics include: how learning skills in therapy relates to symptom change, patterns of change in symptoms during therapy, and the quality of our assessment tools. As the field develops, we may develop additional hypotheses that we want to study with the data in the data repository.

WHAT DATA WILL BE COLLECTED?

Dr. Persons will collect information from your clinical record that does not identify you, including your age, gender, and other demographics, your diagnosis, your personal and treatment history, your symptoms, number of sessions of therapy, and information from questionnaires you completed.

HOW WILL DATA BE COLLECTED?

To transfer data from your clinical record to the repository, Dr. Persons will remove identifying information from the data and transfer the anonymous data into a research database.

WHAT WILL HAPPEN TO THE DATA?

The de-identified database will be stored in a password-protected file on a password-protected and encrypted computer at the Oakland Cognitive Behavior Therapy Center. Backups of the database will be kept in a password-protected and encrypted thumb drive that is kept in a locked cabinet and a HIPAA-compliant storage facility in the cloud. The data will be stored indefinitely.

The de-identified data will be accessible only to researchers at the Oakland Cognitive Behavior Therapy Center and to other researchers who follow the policies and procedures established by the Oakland Cognitive Behavior Therapy Center and the Institutional Review Board of the Behavioral Health Research Collective.

PRIVACY & CONFIDENTIALITY PROTECTIONS

To protect your privacy, the data in the repository do not include any information that will identify you.

RISKS AND DISCOMFORTS

Although we will make every effort to protect your identity, there is an extremely small risk of loss of confidentiality. In the highly unlikely event that the data in the repository should become linked to your identity and distributed to an outsider, sensitive information about you and your therapy could become available to an insurer, employer, relative, or someone else.

BENEFITS

You will not receive any direct benefit from participating in this research repository. Your participation will support research that contributes to advances in scientific knowledge. You can access research reports based on the data from the repository at www.oaklandcbt.com.

COSTS

You will not be paid for providing data for the data repository. There will be no cost to you for contributing to the data repository.

PARTICIPANT RIGHTS

You have a right to refuse to provide data for the repository. **No information about you will be placed in the data repository unless you initial the DATA REPOSITORY section of the Evaluation and Treatment Agreement.** You can also withdraw from participation by notifying Dr. Persons in writing that you wish to withdraw from participating in the data repository. If you withdraw your participation once your data have been entered into the repository, Dr. Persons will have no way to remove it, as your data are not linked to your name or any other identifying information. However, if you withdraw, Dr. Persons will not add new information from your record to the repository. If you refuse to participate or later withdraw your permission to provide data for the repository, you will not suffer any penalty or loss of benefits to which you are otherwise entitled, or give up any legal rights. Your treatment with Dr. Persons will not be affected if you decline to participate in the repository.

OVERSIGHT

Policies and procedures that govern this data repository were approved by the Behavioral Health Research Collective Institutional Review Board, chaired by Travis L. Osborne, Ph.D., 1200 Fifth Avenue, Suite 800, Seattle, WA 98101 (206) 374-0109. Email: collectiveirb@gmail.com. The BHRC IRB is registered with the federal Office of Human Research Protections (OHRP). The BHRC reviews the procedures of this data repository on an annual basis to evaluate its compliance with BHRC standards, OHRP standards, HIPAA regulations, and other applicable standards.

If you have questions, concerns, or complaints about the data repository, you may contact the guardian of the repository (listed at the beginning of this document) or Travis Osborne, Ph.D., Chair of the BHRC IRB (contact information in the preceding paragraph) that oversees the data repository.

RESEARCH SUBJECT INFORMATION AND CONSENT FORM	
TITLE:	Single Case Studies Investigating Therapeutic Mechanisms in Functional Analytic Psychotherapy Enhanced Cognitive Behavior Therapy

This consent form contains important information to help you decide whether to participate in a research study.

- **Being in a study is voluntary – <u>your choice</u>.**
- **If you join this study, you can still <u>stop at any time</u>.**
- **<u>No</u> one can <u>promise</u> that a study will help you.**
- **Do not join this study unless all of your <u>questions</u> are <u>answered</u>.**

After reading and discussing the information in this consent form you should know:

- Why this research study is being done;
- What will happen during the study;
- Any possible benefits to you;
- The possible risks to you;
- Other options you could choose instead of being in this study;
- How your personal health information will be treated during the study and after the study is over;
- Whether being in this study could involve any cost to you; and
- What to do if you have problems or questions about this study.

<u>Please read this consent form carefully.</u>

1. General Information

TITLE:	Single Case Studies Investigating Therapeutic Mechanisms of Change in Functional Analytic Psychotherapy Enhanced Cognitive Behavior Therapy
PROTOCOL NO.:	None
SPONSOR:	Oakland Cognitive Behavior Therapy Center
CO-INVESTIGATORS:	Garret Zieve, B.A Oakland Cognitive Behavior Therapy Center 5625 College Avenue, Ste 215 Oakland, California 94618 Jacqueline B. Persons, Ph.D. Oakland Cognitive Behavior Therapy Center 5625 College Avenue, Ste 215 Oakland, California 94618
SITE(S):	Oakland Cognitive Behavior Therapy Center 5625 College Avenue, Ste 215 Oakland, California 94618
STUDY-RELATED PHONE NUMBER(S):	Garret Zieve, B.A 206-607-7734 Jacqueline B. Persons, Ph.D. 510-662-8405 ext 1

2. Study Description

You are being invited to participate in a research study. Your participation is completely voluntary. You do not have to participate if you do not want to. Whether or not you choose to withdrawal your participation in the study at a later date research will have no impact on the treatment you receive.

Study description:

The aim of this study is to learn about how functional analytic psychotherapy enhanced cognitive behavior therapy leads to good outcomes. Briefly, standard cognitive behavior therapy usually involves identifying and treating problematic patterns of thought and behavior by discussing issues that occur outside the therapy session. In contrast, functional analytic psychotherapy focuses on identifying and changing problematic patterns of thought and behavior that arise in the session

itself, in the relationship to the therapist and the therapy setting. Functional analytic psychotherapy enhanced cognitive behavior therapy is designed to balance the benefits and limitations of these two approaches.

If you have any questions about the study, you may call 206-607-7734 to speak with Mr. Zieve or 510-662-8405 ext 1 to speak with Dr. Persons.

3. Study Procedures

What will I be asked to do if I participate in the study?

Participating in this study does not require doing anything above and beyond what you would do when you are receiving psychotherapy in a training setting. Participating would mean giving the research team permission to use for research purposes, data that are already being collected during the course of your treatment for research purposes. These data include: (1) self-report measures you complete to monitor the process and outcome of treatment, (2) demographic, diagnostic, and other treatment information from the clinical record, and (3) audio and video recordings of therapy sessions. Self-report measures may include the Depression Anxiety and Stress Scales, and the Functional Analytic Psychotherapy Intimacy Scale, or other measures you and your therapist determine are relevant to your case. You and your therapist will determine, based on your clinical needs, how often it makes sense to complete self-report measures. Demographic, diagnostic, and other treatment information from the clinical record include age, gender, ethnicity, marital status, number of years of education, employment status, diagnoses, whether you are receiving psychiatric medication, and information from the intake session and materials, and from the progress notes the therapist keeps to document the therapy sessions. The information will also include the dates of your sessions with your therapist.

4. Risks and Minimizing Risks

What risks will I face by participating in this study?

The main risk you face is a potential loss of privacy as a result of sharing data from your treatment with the research team. To minimize this risk, we take several steps. First we will assign you an ID number, so that research team members who handle your data (except the audio and video recordings) will not know your identity. Only your therapist will know your identity and have access to the master list that links your identity and your research ID number. Second, the information the research team collects from your clinical record will be stored in a research database that does not include your name, address, or any other information that would uniquely identify you. Third, the audio and video session recordings will be individually encrypted and stored on an encrypted hard drive. Fourth, the research team members have been carefully trained to follow ethical and secure research procedures. Fifth, before we begin the research, we submitted our proposed study to an Institutional Review Board that provided an independent review of our procedures to assure that research participants are treated in an ethical and fair manner that protects their privacy and safety.

Another risk you face is feeling pressured to participate in order to receive treatment by the therapist who is conducting this study because the fee for his services reflects the fact that he is a trainee at the Oakland Cognitive Behavior Therapy Center. To minimize this risk, we will work with you to find another low fee therapist if you want low fee therapy but do not want to participate in the research study. In addition, we assure you that you have the right to withdraw from the study for any reason at any time with no penalty. If you withdraw from the study, it will not affect your relationship with your therapist in any way.

You may also contact Mr. Zieve or Dr. Persons at any time if you have any concerns or are feeling any discomfort due to study participation.

You will be told about any new information (such as changes to the study) that might change your decision to be in this study.

5. Benefits

Will I receive any benefit from my participation in this study?

You will not receive any direct benefit from your participation in this study except for the possibility that the intense study of your clinical data for research purposes might lead to improved understanding and treatment of your difficulties.

Are subjects paid or given anything for being in the study?

No.

6. Study Costs

Will I be charged anything for participating in this study?

You will only be responsible for the usual costs of your psychotherapy.

7. Confidentiality

How will information about my treatment be collected?

Your therapist will collect the dates of your therapy sessions, self-report measures, and demographic and diagnostic data, and other information from your clinical record as described in Section 3 above. All sessions will be audio and video recorded.

What happens to the information collected?

Research data that are obtained from your clinical record will be identified solely by your study identification number and will be stored electronically in an encrypted hard drive. All the individual data files will be encrypted individually as well. The encrypted hard drive will be stored in a locked filing cabinet at the Oakland Cognitive Behavior Therapy Center. The key connecting your name and contact information to the identification number will be held only by your therapist and will be stored in a password-protected document. The document will be stored on your therapist's computer in her/his office. This record linking your name to research data through the ID number will be destroyed after the publication of the study or after 15 years, whichever comes first. After the record is destroyed there will be no way to link your name to your responses.

The audio and video recording of sessions will also be individually encrypted and stored on the study hard drive. The audio files (not the video files) will be transcribed for study purposes. The audio files will be transmitted securely to research personnel and a HIPAA compliant transcription service for transcription. Only the investigators (Mr. Zieve and Dr. Persons and the research assistants they supervise) will have access to the video files. The audio and video files will be destroyed after the publication of the study or after 15 years, whichever comes first.

Only the research team and your therapist (who leads the research team) will have access to your data. The research team will analyze the data to test hypotheses about the relationships among the various types of data and will publish the results in scientific papers and present them at scientific conferences. When we present the research findings to others or publish our results in scientific journals or at scientific conferences, the findings will be presented without any information that identifies you.

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. The BHRC Institutional Review Board or appropriate federal agencies like the Office for Human Research Protections may review the data.

8. Alternatives

Are there alternatives to participating in the study?

If you do not want to participate, you are free to not sign this consent form. If you do choose to participate, you can withdraw from the study at any time.

9. Voluntary Participation and Withdrawal

What happens if I decide not to be in this study?

If you decide not to be in this study, the therapist (Mr. Zieve) will help you obtain psychotherapy from another provider if you would want his assistance doing that. Your participation in this study may be stopped at any time by the study staff or the sponsor without your consent for any of the following reasons:

- if in their judgment it is in your best interest;

- you do not consent to continue in the study after being told of changes in the research that may affect you;
- or for any other reason.

10. Questions

Who do I contact for questions about this study?

For more information about the study or the study procedures or treatments, or to withdraw from the study, contact:

Garret Zieve, B.A
Oakland Cognitive Behavior Therapy Center
206-607-7734

or

Jacqueline B. Persons, Ph.D.
Oakland Cognitive Behavior Therapy Center

510-662-8405 ext 1

Who do I contact for questions about my rights or complaints about my participation as a research subject?

If you have questions about your rights as a research subject or if you have questions, concerns or complaints about the research, you may contact:

Behavioral Health Research Collective (BHRC) IRB
Attn: Chair: Travis L. Osborne, Ph.D.
1200 Fifth Avenue, Suite 800
Seattle, WA 98101
(206) 374-0109
Email: collectiveirb@gmail.com

BHRC IRB is a group of people who perform independent review of research. BHRC IRB will not be able to answer some study-specific questions, such as questions about appointment times. However, you may contact BHRC IRB if the research staff cannot be reached or if you wish to talk to someone other than the research staff.

11. Signatures

Research Subject's Consent to Participate in Research:
To voluntarily agree to take part in this study, I must sign on the line below. If I choose to take part in this study, I may withdraw at any time. I am not giving up any of my legal rights by signing this form. By signing my full name below, I indicate that I have read this entire consent form, including

the risks and benefits, have had all of my questions answered, and am 18 years of age or older. I freely consent to be in this research study.

_____ _____

Signature Date

_____

Printed Name of Participant

Authorization Form for the Use and Disclosure of Patient Health Information

By signing this Authorization Form, I am allowing my therapist and her/his designated medical record custodians to use and/or disclose my Protected Health Information, as described below, to the following person(s) or organization(s) as part of my participation in the research study at the Oakland Cognitive Behavior Therapy Center:

Name of person(s) or organization(s):

	Garret Zieve, B.A.
	Oakland Cognitive Behavior Therapy Center
Street address:	**5625 College Avenue, Ste 215**
City, state and zip code:	**Oakland, CA 94618**
Telephone number:	**(206) 607-7734**
Email:	**ggzieve@berkeley.edu**
	Jacqueline B. Persons, Ph.D.
	Oakland Cognitive Behavior Therapy Center
Street address:	**5625 College Avenue, Ste 215**
City, state and zip code:	**Oakland, CA 94618**
Telephone number:	**510-662-8405 ext 1**
Email:	**persons@oaklandcbt.com**

I specifically authorize the use and/or disclosure of the following Protected Health Information:

X Mental Health/Psychiatric Care: **Dates of therapy sessions, therapy outcome and process measure scores, video and audio recordings of therapy sessions, as well as information about age, gender, ethnicity, marital status, number of years of education, employment status, diagnoses, whether you are receiving psychiatric medication, and information from intake reports and other reports, and from progress notes used to document the therapy.**

This Protected Health Information is being used or disclosed for the following purposes:

X Research (provide a description of the purpose of the study): **The aim of this study is to learn about how functional analytic psychotherapy enhanced cognitive behavior therapy leads to good outcomes. The pieces of PHI described above are needed to investigate this aim.**

I may revoke this authorization at any time by notifying my therapist in writing of my intent to revoke the authorization. Such a revocation will not have any effect on any information already used or disclosed before my therapist receives my written notice of revocation.

Unless earlier revoked, this authorization will expire:

X Upon my request.

X Unless earlier revoked, this permission expires 15 years after the end of the study.

When I withdraw my permission, no new health information from me will be gathered after that date, and information that has already been gathered will not be used for research purposes.

Information used or disclosed after this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I may inspect and receive a copy of the information to be used and disclosed after this authorization form.

I may refuse to sign this authorization form and my refusal to sign will not affect my ability to obtain payment or my eligibility for benefits but I will not be able to participate in this research study.

Authorization:

I have been given the information about the use and disclosure of my health information for this research study. My questions have been answered.

I authorize the use and disclosure of my health information to the parties listed in the authorization section of this consent for the purposes described above.

_____ _____

Signature Date

_____

Printed name