

Dear Student:

Only a limited amount of counseling hours have been allotted to us. These times are very important and by far do not fulfill the need for student counseling.

Therefore, it is imperative that if you cannot keep your appointment you call at least twenty-four (24) hours in advance to cancel. Your appointment time can then be used for other students in need of counseling.

Thank you for your cooperation on this matter.

I have read and understand the above.

---

Student Signature

---

Date

**Confidential Intake Form**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_ Employer: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Medi-Cal: (Y) \_\_\_\_\_ (N) \_\_\_\_\_ ID# \_\_\_\_\_  
(If yes, please list)

Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
May we leave a message? Yes No May we leave a message? Yes No

Emergency Contact: \_\_\_\_\_

How did you learn about our counseling services?  
 self  friend  instructor  other \_\_\_\_\_

Please describe the reason for your visit today:  
\_\_\_\_\_  
\_\_\_\_\_

**MAIN ISSUES OF CONCERN:** Please check all that apply.

- depression  anxiety/stress  alcohol/other drug use  suicidal ideation
- sexual issues  eating disorders  low self esteem  separation
- grief, loss  finances  learning disability  sexual, physical and/or emotional abuse
- studying/test taking  poor grades  sleeping  change in appetite
- relationships with:  friends  family  instructors  other

**COUNSELING HISTORY:**

Are you currently receiving counseling? yes \_\_\_\_\_ no \_\_\_\_\_  
Name: \_\_\_\_\_ Address: \_\_\_\_\_

Have you previously received counseling? yes \_\_\_\_\_ no \_\_\_\_\_  
Name: \_\_\_\_\_ Address: \_\_\_\_\_

**CURRENT HEALTH STATUS:**

Current illnesses: \_\_\_\_\_ Current medications: \_\_\_\_\_

Chronic illnesses: \_\_\_\_\_ Recent medications: \_\_\_\_\_

Alcohol/Drug Use:  weekly  daily  occasionally  none

How many times per week do you exercise? \_\_\_\_\_

**CLASS SCHEDULE:** Major \_\_\_\_\_ Total Units \_\_\_\_\_

I agree to receive counseling services from the COC counseling staff and understand the client rights and stated limitations of confidentiality.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COLLEGE OF THE CANYONS**  
**STUDENT HEALTH & WELLNESS CENTER**  
**COUNSELING SERVICES**  
*Limits of Confidentiality*

---

Information discussed in the therapy setting is held confidential and not shared without written permission except under the following conditions:

1. If the student threatens suicide.
2. If the student threatens harm to another person(s), including murder, assault, or other physical harm.
3. If the student under eighteen (18) reports that he/she is being abused, including but not limited to, physical beatings and sexual abuse.
4. Child abuse, elder abuse, and dependent adult abuse- Reporting is legally mandated when there is knowledge or "reasonable suspicion" drawn from any professional contact.
5. If there is a concern for the safety of students, staff or faculty of the College of the Canyons.
6. If ordered by a Federal or State court or if student has been referred to the College of the Canyons Behavioral Intervention Team (BIT).

State law mandates that counseling professionals must report these situations to the appropriate persons and/or agencies. Further, as a registered intern/trainee who is under the supervision of a licensed practitioner, therapy sessions will be discussed with a supervisor as deemed under the laws of the state. Communications between the counselor and student will otherwise remain confidential under the laws of the state.

**COUNSELING POLICIES**

Eligibility for counseling at the Student Health & Wellness Center is contingent upon my status as a fully enrolled student. Counseling is intended for short-term problems and/or crisis intervention. Counseling services are offered during Student Health Center normal business hours only and there are no after-hours crisis services available. In the event of a life threatening emergency students are advised to call 911 or go to the nearest emergency room. Students are also advised that the National Suicide Hotline is available at 1-800-273-TALK (8255) 24/7. Services are offered on a first come, first serve basis and are voluntary. Delivery of services from the Student Health & Wellness Center shall be based upon the mutual determination of myself and the staff as to the appropriateness of the services for the needs presented. The counselor, if he/she sees the need, will consult with other COC Student Health & Wellness Center medical, dietetic or counseling staff. If Student Health & Wellness Center staff are unable to provide services, I understand that I will be given referrals to resources more appropriate to my needs and goals.

Students are entitled to a maximum of six (6) sessions per semester. If a twenty-four (24) hour notification of cancellation or change is not given, appointment will count as one of your scheduled visits. If you are more than ten (10) minutes late for your appointment, we reserve the right to give your time to another student and your scheduled session will count as one (1) of your appointments. Services may be provided by either of the following: Psychologist, LCSW, LMFT, MFT Trainee/Intern or other training clinician under the direct supervision of a licensed mental health professional.

Having read and understood the above, I agree to the limits of confidentiality and to the policies of the Student Health & Wellness Center regarding counseling services.

Student Name (please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COLLEGE OF THE CANYONS**  
STUDENT HEALTH & WELLNESS CENTER  
**COUNSELING SERVICES**  
*Limits of Confidentiality*

---

Information discussed in the therapy setting is held confidential and not shared without written permission except under the following conditions:

1. If the student threatens suicide.
2. If the student threatens harm to another person(s), including murder, assault, or other physical harm.
3. If the student under eighteen (18) reports that he/she is being abused, including but not limited to, physical beatings and sexual abuse.
4. Child abuse, elder abuse, and dependent adult abuse- Reporting is legally mandated when there is knowledge or "reasonable suspicion" drawn from any professional contact.
5. If there is a concern for the safety of students, staff or faculty of the College of the Canyons.
6. If ordered by a Federal or State court or if student has been referred to the College of the Canyons Behavioral Intervention Team (BIT).

State law mandates that counseling professionals must report these situations to the appropriate persons and/or agencies. Further, as a registered intern/trainee who is under the supervision of a licensed practitioner, therapy sessions will be discussed with a supervisor as deemed under the laws of the state. Communications between the counselor and student will otherwise remain confidential under the laws of the state.

**COUNSELING POLICIES**

Eligibility for counseling at the Student Health & Wellness Center is contingent upon my status as a fully enrolled student. Counseling is intended for short-term problems and/or crisis intervention. Counseling services are offered during Student Health Center normal business hours only and there are no after-hours crisis services available. In the event of a life threatening emergency students are advised to call 911 or go to the nearest emergency room. Students are also advised that the National Suicide Hotline is available at 1-800-273-TALK (8255) 24/7. Services are offered on a first come, first serve basis and are voluntary. Delivery of services from the Student Health & Wellness Center shall be based upon the mutual determination of myself and the staff as to the appropriateness of the services for the needs presented. The counselor, if he/she sees the need, will consult with other COC Student Health & Wellness Center medical, dietetic or counseling staff. If Student Health & Wellness Center staff are unable to provide services, I understand that I will be given referrals to resources more appropriate to my needs and goals.

Students are entitled to a maximum of six (6) sessions per semester. If a twenty-four (24) hour notification of cancellation or change is not given, appointment will count as one of your scheduled visits. If you are more than ten (10) minutes late for your appointment, we reserve the right to give your time to another student and your scheduled session will count as one (1) of your appointments. Services may be provided by either of the following: Psychologist, LCSW, LMFT, MFT Trainee/Intern or other training clinician under the direct supervision of a licensed mental health professional.

Having read and understood the above, I agree to the limits of confidentiality and to the policies of the Student Health & Wellness Center regarding counseling services.

Student Name (please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **Student Health & Wellness Center**

### **CLIENT'S BILL OF RIGHTS**

#### **You have the right to:**

- **Receive respectful treatment that will be helpful to you; receive a particular type of treatment without obligation or harassment;**
- **A safe environment, free from sexual, physical and emotional abuse;**  
**Report unethical and illegal behavior by a therapist;**
- **Ask questions about your therapy;**
- **Request and receive information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations;**
- **Refuse to answer any question or disclose any information you choose not to reveal;**
- **Know the limits of confidentiality and the circumstances when 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;**
- **Request, and in most cases, receive a summary of your file including the diagnosis, your progress, and type of treatment;**
- **Request the transfer of a copy of your file to any therapist or agency you choose;**
- **Receive a second opinion at any time about your therapy or therapist's methods;**
- **Request that the therapist inform you of your progress.**

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING   0   + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

=Total Score: \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult  
at all  
⑤

Somewhat  
difficult  
⑤

Very  
difficult  
⑤

Extremely  
difficult  
⑤



## Student Health & Wellness Center Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please review it carefully.

1. This practice may use or give out your health information for the following reasons:

Treatment:

We give information to those involved in your care. Our staff, specialists we refer you to, pharmacists, lab personnel, as appropriate.

Payment:

We give out information to get paid for our services from funding sources and/or programs that you may be enrolled in to receive benefits. (FamilyPACT and/or Student Accident Insurance)

Health care operations:

- Quality Assurance programs to improve our services
  - Audits by agencies funding our operation or providing benefits
  - Insurance companies to authorize services or referrals
  - Business associates as appropriate (nutritionist/mental health providers, nurse practitioners, RN, athletic trainers, etc.
  - Applications for programs/agencies designed for your specific needs
  - Contacting you. Appointment reminders, messages for follow-up exams or lab results, etc. at the contact information you provide
  - We will call your first name when the provider is ready to see you
  - Federal or state government auditing privacy practice compliance
  - Gathering health or demographic information for statistical purposes that can not be traced back to you.
2. The health center will not use or give out health information for any reason not listed without your written authorization. You can revoke this authorization at any time.
  3. The health center is required to give out health information **without your consent** in two circumstances: Required by law or public health.
  4. The health center will abide by the terms of this notice but reserves the right to change the terms when necessary and provide any changes to you at the next visit. Copies of this notice will be posted in the waiting room and provided on request.

## Privacy Rights

As a patient of the Student Health & Wellness Center you have the right to:

- Ask us not to share the health information in the ways described in the privacy notice. This will affect any programs you are entitled to and we may not be able to agree with your request.
- Ask us to contact you only in writing or at a different address or phone number. We will accept reasonable requests to protect your safety.
- To see a copy of your medical record. Written requests for specific information must be provided with 72 business hour notice. You may be charged a fee for copying or mailing. We may keep you from seeing all or part of the record for reasons allowed by law. Including your mental health record.
- Change the record if you believe some information we have about you is wrong. If your change request is denied, a copy of your letter will be kept in the record.
- You have the right to withdraw or revoke your authorization. If you revoke your authorization, it is only effective after the date of your written revocation, or withdrawal using the designated form.

If you want these rights explained or if you wish to file a complaint about the health center not protecting your privacy please contact:

Mary Manuel, NP  
Director, Student Health & Wellness Center  
26455 Rockwell Canyon Road  
Santa Clarita, CA 91355  
(661) 362-3259

Or:

Secretary of the Department of Health & Human Services by writing to:  
The U.S. Department of Health & Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(877)696-6775

No Action will be taken against anyone whom files a complaint.

Date: \_\_\_\_\_ Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

- A copy can be provided to you at any time by request.