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

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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.

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Thank you for your cooperation on this matter.

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_____ _____

Student Signature Date

CONFIDENTIAL INTAKE FORM

Name: _____ **Date of Birth:** _____ **Student ID#:** _____

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: _____

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Student Name (please print) _____

Signature:_____ Date: _____

COLLEGE OF THE CANYONS

Telehealth Informed Consent Form

California law has long recognized telehealth as a form of delivery of health care and behavioral health services which many psychotherapists are practicing in the state of CA (Business Professional Code - BPC Article 12. Enforcement 2290.5) and the U.S. In California, "Telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites. This form of service is usually live video conferencing through a personal computer with a webcam.

I _____ hereby consent to engaging in telehealth with the following College of the Canyons Student Health and Wellness Center provider(s) as part of my psychotherapy/medical treatment. I understand that "telemedicine or telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California. I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an identifiable victim and/or self; and where I make my mental or emotional state an issue in a legal proceeding.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area.

4. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. If you have an emergency, feel suicidal, or homicidal please: • Call 911 • Call the LA Psychiatric Mobile Response Team at 1-800-854-7771 • Go to the nearest Hospital Emergency Room • Call the Suicide Hotline 1-800-273-8255 available 24 hours a day. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

5. I understand that I have a right to access my medical information and copies of medical records in accordance with California law. I have read and understand the information provided above.

Signature_____ **Date**_____

Student ID_____

Full Name _____ **Date of Birth** _____

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	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

COLLEGE OF THE CANYONS

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 cannot 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:

Student Health & Wellness Center Director
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.