Oklahoma City University
Counseling Center
Student Intake Information

**Please complete all items. Please ask counselor for assistance if you have questions about any item. Thank you!*

I. Identification

A. Date completed _____/_____/_____

B. Legal Name: _____

1.Preferred Name_____

2.Personal Pronouns_____

C. Date of Birth: _____/_____/_____

D. B Number: _____ E-mail: _____

E. Major: _____

F. Student Classification and anticipated graduation date: _____

G. How did you find out about the Counseling Center? _____

H. Race/Ethnicity: _____

I. Oklahoma City University Address: _____

City: _____ State: _____ Zip: _____

Permanent Housing Address: _____

City: _____ State: _____ Zip: _____

J. Home Telephone: _____ Cell Telephone: _____

Work Telephone: _____

K. What is your current living arrangement?

___Living on campus ___Living Off Campus ___Other, Explain:

_____

_____

L. Please list persons in your current living situation:

Name	Age	Relationship to you

M. Name of Emergency Contact: _____

Telephone: _____ E-mail: _____

II. Presenting Concern

What is/are the concern(s) you are seeking help with?

How long has this been a concern?

III. Personal History

**Please <u>BRIEFLY</u> answer the following questions:*

Briefly describe your relationship with your parents.

Briefly describe your home environment while growing up.

Describe your experiences in school prior to college i.e. friends, activities, interests.

Describe your college experience in terms of friends, activities and course load.

Briefly describe significant relationships in your life. Who is your support system?

List any medical problems that you have experienced in your life.

Have you received counseling or mental health treatment in the past? If so, when was your most recent treatment?

_____
_____
_____

Are you currently having suicidal thoughts?

_____
_____
_____

Have you ever had any suicidal thoughts?

_____
_____

*If yes, specify when:

Past 4-6 weeks_____ Past 3-6 months_____ Past year_____ Other_____

Please list any medications, including vitamins or over the counter drugs you are currently taking:

_____

Describe any drug or alcohol use including difficulty that it may have caused you in the past.

_____
_____
_____

Describe any history of head injuries that you have experienced in the past.

_____
_____
_____

When was your last physical medical exam?

_____

Oklahoma City University
Counseling Services
Consent to Receive Services

I consent to receive evaluation, treatment, and/or support services from Oklahoma City University Counseling Services. I understand that consenting to services does not waive my rights as recognized under federal and state regulations.

The staff of OCU Counseling Services must adhere to the ethical and professional guidelines set forth by the American Psychological Association and American Counseling Association, regardless of what type of assistance the student is seeking. Information disclosed to the counselor is confidential, with the only exceptions to this confidentiality being listed below, and will not be revealed to outside sources without the student's prior written consent or express specific verbal consent.

I understand that my communication with OCU Counseling Services staff and my treatment records are confidential and may not be released under the following conditions or circumstances or there otherwise provided by federal and state regulations, such as:

- Upon my express written consent to enable and ensure collection of third party payment for services rendered and other purposes for which I give consent.
- Upon the need to disclose information to protect the rights and safety of myself or others if:
    1. I present a clear and present danger to myself and refuse explicitly or by behavior to voluntarily accept appropriate treatment; OR
    2. If I communicate an explicit threat to kill or inflict serious bodily injury upon an identified person with the intent and ability to carry out the threat; OR
    3. If I have a known history of physical violence and the treatment staff has a reasonable basis to believe there is a clear and imminent danger that I will attempt to kill or inflict serious bodily injury upon an identified person.
- As required for supervised review by funding sources and/or accreditation bodies in order to verify evaluation the provision of my services.
- As required by state laws in the reporting of alleged acts of child abuse and/or neglect

I understand that there will be a $100 charge for a Drug and Alcohol Assessment if such is required by the student conduct board or Dean of Students. In addition, should I miss two consecutive appointments without prior cancellation, I acknowledge that I will be charged $50 on my student account. By providing my signature I am allowing student financial services access to may information in order to process the charge.

I understand that in entering treatment, I must conduct myself in such a way as to protect myself and others from exposure to, or transmission of, any infectious or communicable disease including sexually transmitted diseases.

_____

Student's Printed Name **Student Signature (or parent if under 18 years of age)**

_____

Staff Signature **Date**

University Counseling
OKLAHOMA CITY UNIVERSITY

Client Bill of Rights

1. **Each client has the right to be treated with respect and dignity. University Counseling Center will promote basic human dignity and respect for the individual who is receiving services.**
2. **Every client shall have a right to a safe, sanitary, and humane treatment environment that protects them from harm, abuse and neglect. The client has a right to an environment that provides privacy, promotes personal dignity and provides opportunity for improved functioning.**
3. **Every person shall receive service or appropriate referral without discrimination as to race, age, gender, identity, marital status, sexual orientation, pregnancy, religion, national origin or degrees of ability.**
4. **The client's case record may be made available upon their express written consent in cases requiring verification of services which include, but are not limited to legal cases, military service, or physical health evaluations.**
5. **The client has the right to refuse services at any time.**
6. **An individual can expect an explanation concerning the reason they refused certain services.**
7. **All information will be held in confidence according to policies and procedures of University Counseling Center and the federal guidelines of HIPPA. The client is assured of their rights against current or future disclosure of unauthorized information.**
8. **The client shall participate in treatment and service planning to the extent of their ability.**
9. **The client has the right to file a grievance in the event that the person feels that they have been treated unfairly.**

Office of University Counseling
2501 N. Blackwelder Oklahoma City, Oklahoma 73106 T: 405.208.7901 F: 405.208.7906
www.okcu.edu/campus/resources/counseling/

Oklahoma City University
Counseling Center
Informed Consent

Welcome to Oklahoma City University's Counseling Services. Our goal is to provide short-term mental health services that will assist OCU students with emotional development, problem solving and decision making capabilities and to provide educational outreach to the wider community of OCU of students, faculty, and staff.

ELIGIBILITY FOR SERVICES:

The following are eligible to receive services from Oklahoma City University Personal Counseling:

Full and part-time students in good conduct standing with active enrollment at the time of services. Full and part-time faculty, staff, and employees may participate in outreach education and trainings but will be referred to the EAP for counseling services.

WHAT YOU CAN EXPECT:

You will be treated with dignity and respect. Therapy is not always easy; you may have feelings of frustration or feel your symptoms are worsening during the process. It is important to communicate any such feelings to your therapist.

1. Sessions are typically 45 to 50 minutes.
2. OCU personal counseling services are free of charge.
3. Services may be terminated at any time at the discretion of the counselor for any reason. In the event of termination, appropriate referrals will be made. (ACA Code of Ethics A 11 a, b, c)
4. Services are designed to be short-term, but University Counseling will take into consideration mitigating factors such as ability to pay outside services, transportation, etc. However, the counselor may, at the most ethical benefit to the client, refer to outside services based on the treatment needs of the client. Once a client is working with an off-campus provider, the client will no longer seek on campus services from the counselor. Emergent cases will be seen on as needed basis in this case. (ACA Code of Ethics A 11 d, A 12 A 3)
5. Counselors do not provide letters for emotional support animals (ESA). Counselors can assist in providing referrals for off campus providers in this event.
6. Counselors can provide a letter of support involving a request to withdraw from the university due to issues involving mental health if the student is a current client and seen within the semester of the request.
7. Records are kept secured and on file for six years. You may request a synopsis of the records for use in transferring services or for assistance in wrap-around medical care but all records are the property of University Counseling and will not be released. (ACA Code of Ethics, B 6e)
8. Counselors are prohibited from engaging in personal virtual relationships with clients through social and other media (ACA Code of Ethics A 5 e)
9. Interpersonal, romantic, and sexual relationships with clients are prohibited (ACA Code of Ethics A 5 a)

HIPAA - Counseling services are confidential. A written release signed by the client is required for information to be given to anyone by your OCU therapist. There are limits to confidentiality, however:

1. Disclosure of a plan to harm self or others
2. Disclosure of knowledge of child abuse and neglect
3. A signed subpoena by a judge requesting records

Your therapist may utilize a consultant within the office for the purposes of providing better services to you. Consultants are licensed mental health professionals with experience in case consultation. All information discussed with the consultant is kept confidentially by both parties and names of the clients are confidential.

WHAT WE EXPECT:

If you need to cancel please do so within 24 hours of the scheduled appointment. If you need to cancel last minute, a phone call or email to our office is appreciated. The office number is 208-7901.

1. Please be on time for sessions. Should you miss more than 2 consecutive sessions, your file may be closed and a referral to an outside provider may be provided.

A $50 "no show" fee will be incurred on your student account, should you miss 2 consecutive sessions. If you are **more than 15 minutes late** for a session, and you have not called, **you will be asked to reschedule**.

2. If the counselor needs to cancel, the counselor will contact you as soon as possible to reschedule as soon as possible.
3. If you are here for a Drug and Alcohol Assessment, there will be a ***$100*** charge to your student account.

Should you have an after-hours emergency please contact the OCU Police department at 208-5001. You can also utilize any of the following hot lines:

Hopeline: http://hopeline.com
National Suicide Prevention Lifeline 1-800-273-TALK
YWCA Domestic Violence Hotline 917-9922
YWCA Rape Crisis Hot Line 943-7273
www.211oklahoma.org

The following are some local inpatient options:

St. Anthony's ER-1000 N. Lee, OKC, OK 73102 405-272-7000
Oakwood Springs 13101 Memorial Springs Ct. OKC, OK 73114 405-438-3000
Integris Mental Health 405-951-2273
Bethany Behavioral 7600 NW 23rd, Bethany, OK 73008 405-792-4330

*Should you need accommodation due to a disability under the American with Disabilities Act please contact the Senior Coordinator for Access and Academic Support at or 208-5895. Advance notice is required for many accommodations.

Consent to Receive Services

Telehealth

Oklahoma City University

I, the undersigned, agree to participate in technology-based consultation and other healthcare-related information exchanges with _____, a behavioral health care practitioner ("practitioner") with Oklahoma City University Counseling. This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment. It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application" (abbreviated as "app"). I understand there may be other healthcare options available. My behavioral health care provider has explained the alternative to my satisfaction.

Equipment: I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised. Identification: ... I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access. Telebehavioral Health Process: My health care practitioner has explained how the telebehavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Electronic Presence: ... In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or will be transmitted electronically to each other.

Limitations: Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks: I understand that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons. In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.

Release of Information: I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, birth date, symptomology, treatment plan and other clinical or medical record information.

Discontinuing Care: I understand that at any time, the consultation(s) can be discontinued by me. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me. I

acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.

Limits of Confidentiality: ... I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report intents of harm to self or others or specifics of knowledge of child abuse or neglect.

Alternatives: … The alternatives to the sessions have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person sessions from alternate sources. I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation's effectiveness.

Records: … I understand that my telebehavioral sessions will be stored electronically as part of my medical records. I understand that sessions and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my records and that copies of records of sessions are available to me on my written request.

I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy. I hereby authorize these disclosures to take place without prior written consent.

Contact Information: I have received a copy of my practitioner's contact information, including his or her name, telephone number, license number and e-mail address. I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency. Emergency Care: I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a session. Instead, I agree to seek care immediately at the nearest hospital.

Final Agreement: I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telebehavioral sessions, including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described here.

_____ Name/Date

_____ Clinician/Date

Informed Consent and Telehealth

Oklahoma City University Counseling

As a client or patient receiving behavioral services through Doxy.me, a telehealth technology, I understand:

Telehealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client who are not in the same physical location. The interactive technologies used in telehealth incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols: Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. Benefits & Limitations: This service is provided by technology for telehealth and imaging purposes for use during telehealth counseling sessions. There are benefits and limitations to this service. Technology Requirements: I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

Exchange of Information: The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery. During my telehealth consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Counselors or Practitioners: If a need for direct, in-person services arises, it is my responsibility to contact practitioners in my area such as _____ or to contact my behavioral practitioner's office for an in-person appointment or my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in either office.

Self-Termination: I may decline any telehealth services at any time without jeopardizing my access to future care, services, and benefits. Risks of Technology: These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan: My counselor and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed. It is my understanding that telehealth through Oklahoma City University are short term and only applicable during the time of off-campus instruction.

Emergency Protocol: In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means: In emergency situations, my counselor will verify my physical location prior to beginning session and contact 911. Disruption of Service: Should service be disrupted counselor will make two attempts to regain the connection. If this fails, counselor will follow up with an email and will call the client using Skype For Business which is HIPPA compliant.

My counselor will respond to communications and routine messages within 24 hours. Client Communication: It is my responsibility to maintain privacy on the client end of communication. If confidentiality is compromised the videochat will cease immediately. I also understand I need to physically be in the state in which my counselor is licensed. Failure on my part to do so will result in immediate termination of the session and a referral for local services. I will take the following precautions to ensure that my communications are directed only to my counselor or other designated individuals: I will find a quiet, confidential location in which to conduct my session that will be free from distraction.

Storage: My communication exchanged with my counselor will be stored in the following manner: electronically and safely encrypted until they are able to be printed off and safely and confidentially stored.

Laws & Standards: The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Billing: Client will be billed $50 for two missed appointments without cancellation within 24 hours.