AUSTIN COLLEGE | Counseling Services

Guidelines for Counseling Services

Client Assurances:

In using the services of the Counseling Center, you have certain assurances, among which are:

A. CONFIDENTIALITY: The Austin College Counseling Services follows established privacy standards and procedures mandated by state and federal laws pertaining to confidentiality and release of information. All records are confidential. **Material revealed in counseling will remain strictly confidential with the following exceptions in accordance with state law:**

1. The client signs a written release of information indicating informed consent to such release
2. Counselee is under 18 years of age
3. The client expresses serious intent to harm himself/herself or someone else
4. There is evidence or reasonable suspicion of abuse/neglect against a minor child, elderly person (65 or older), or a dependent adult
5. A subpoena or other court order is received directing the disclosure of information. Our policy is to warrant either privileged communication in the event of a subpoena or the right to consult with clients, if at all possible, barring an emergency, before mandated disclosure in the event of (2) or (3).

*Therapists do not guarantee confidentiality among joint participants in therapy, though use professional discretion in disclosing communications.

Your records are NOT part of your academic or administrative records.

Some states, including Texas, ask about therapy as part of application to the bar. Some state medical boards request this information as well. Similar information is requested by some religious denominations prior to ordination. Some federal agencies require releasing this information for applicants applying for sensitive government positions. We respond to requests with brief summaries, which have, to date, been sufficient. This information is only released with your written consent.

Our standards are governed by American Counseling Association Code of Ethics and American Association for Family Therapy Code of Ethics.

B. PROMPT SERVICE: Counseling will begin soon after you contact the Center for an appointment. You may contact the Center at 903.813.2247 or by coming directly to the Adams Center between the hours of 8:30 am to 5:00 pm, Monday through Friday. **Emergency situations** are given priority, and should such circumstances arise after regular Center hours, counseling staff can be reached by calling Campus Police at 903.813.2555 and requesting the officer to reach the counselor on call.

C. DURATION OF COUNSELING: Counseling services focus on brief-therapy model, with an average of three to six sessions for most students receiving services. At the discretion of the Coordinator of Counseling Services, exceptions may be made to insure continuity of care or to permit a student in crisis to reach the end of an academic term. Counseling services are not available during summer break and students who wish to continue services at the beginning of the next academic year may be asked to submit new paperwork to update information.

D. COST: There is no cost to Austin College students for counseling services received at the Center.

E. EVALUATION: You are encouraged to discuss your progress and review your goals on a regular basis with your counselor.

F. QUESTIONS: Please feel free to ask questions about any procedures and recommendations made to you by your counselor. If you feel that suggestions made to you are not appropriate, you may refuse to accept them. The counseling relationship should be collaborative, with you as an active participant.

G. TERMINATION: Termination of counseling services may occur for different reasons and will always be discussed with you prior to termination.

- You feel that you are not making progress towards your goals, you may terminate services or request to be referred to another counselor at the center or to other services off campus,

- Counselor may terminate the counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling,

- You withdraw from Austin College.

Counselor Assurances:

In an effort to provide students with the best care possible, your counselor may:

A. SEEK CONSULTATION WITH OTHER PROFESSIONALS: While information will not be released to outside agencies without your written permission, counselors may confer with other professionals, including Michael Deen, Dean of Students and/or Tim Millerick, Vice President of Student Affairs, when presented with situations that require consultation, diagnosis, or treatment.

B. TERMINATE OR REFER TO ANOTHER AGENCY: When services are not, or will not be appropriate, your counselor may, after discussing concerns with you, decide to end treatment or refer you to a more appropriate provider.

Counselor Responsibilities:

A. ADHERENCE TO THE ETHICAL STANDARDS OF THE AMERICAN COUNSELING ASSOCIATION: These standards require that counselors and those under their supervision:

1. work only within the limits of their expertise and competence levels;
2. safeguard information about clients obtained through interviews, testing, consultations;
3. inform clients of any aspects of the potential client/counselor relationship which might influence the client's decision to enter into or continue counseling (e.g., possible value and role conflicts);
4. ensure that tests results are interpreted clearly and accurately by qualified persons and are used in responsible ways;
5. protect the welfare and dignity of the clients they serve at all times.

B. KEEPING APPOINTMENTS: If the counselor expects to be late for an appointment or has to cancel a session, reasonable effort will be made to notify you by phone or email. Therefore, it is important that you provide the Center with a current phone number by which you can be reached during the day. Messages for you will be left on your voicemail whenever possible or, if someone besides yourself answers the phone, a message will be left for you with the receptionist's or counselor's first name and phone number.

Client Responsibilities:

A. To Actively Participate: In order for counseling to be effective, it is necessary for you to take an active role in the process. Participation involves listening, being open and honest, and discussing concerns about the process, completing outside assignments when appropriate, and providing feedback to the counselor about the process.

B. To Keep Appointments: Since the counseling service often has a full schedule, it is unfair to the counselor and to other students if you arrive late for an appointment, or if you do not cancel an appointment by calling the receptionist when you are unable to keep it. As a courtesy to our staff, please contact the Center as soon as you know that an appointment will not be kept. If a 24 hour advance notice is possible, it would be appreciated.

C. To Inform the Counselor if You Decide to Terminate or Seek Other Services: Termination is part of the counseling process and should be discussed openly just as any other mutually arrived at decision.

D. Your Cooperation is Expected in Evaluating the Services You Have Received: This may mean completing a brief questionnaire that you may receive during or sometime after you have received services from the counselor.

Thank you for taking the time to read these guidelines. If you have any questions about the information provided here, feel free to ask them to the counselor. The purpose of this information is to make your contact with Counseling Services more productive and satisfying.

_____ _____

Signature Date

A COPY OF THIS HANDOUT WILL BE PROVIDED TO YOU UPON REQUEST.

Austin College Counseling Services

Your careful completion of this inventory will help the counselor become better acquainted with you. It will enable the counselor to know you better and to help you more effectively with your concerns. The information you share is confidential and used only by the counselor.

NAME _____ STUDENT ID _____
Last First

DATE OF BIRTH _____ AGE _____ GENDER: M ☐ F ☐

CELL #_____ EMAIL _____

CAMPUS MAILBOX_____ BEST WAY TO REACH YOU: Phone ☐ Email ☐

RESIDENCE HALL _____ ROOM # _____ GREEK ORG _____

ADDRESS (Off Campus) _____

HOME ADDRESS _____
Street City State Zip

CLASSIFICATION: FR ☐ SO ☐ JR ☐ SR ☐ MAJOR_____

EMPLOYMENT_____ HRS/WEEK_____

WHO REFERRED YOU OR SUGGESTED THAT YOU COME TO COUNSELING SERVICES?
(THIS INFORMATION IS CONFIDENTIAL UNLESS YOU SIGN A RELEASE OF INFORMATION)

☐ SELF ☐ PARENT ☐ FRIEND

☐ AUSTIN COLLEGE FAULTY/STAFF (PLEASE SPECIFY)

☐ OTHER (PLEASE SPECIFY)

DO YOU HAVE A MENTAL HEALTH DIAGNOSIS? YES ☐ NO ☐
IF SO, WHAT IS IT? _____

DO YOU HAVE A HISTORY OF MENTAL HEALTH HOSPITALIZATION? YES ☐ NO ☐ N/A ☐
IF SO, WHAT IS THE MOST RECENT DATE? _____

DO HAVE A PSYCHIATRIST, PSYCHOLOGIST, OR COUNSELOR? _____

IF SO, NAME _____ PHONE # _____

LIST ANY MEDICAL CONDITIONS WHICH YOU FOR WHICH YOU ARE CURRENTLY BEING TREATED

_____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

_____

FAMILY BACKGROUND

PARENT'S MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SEPARATED

FAMILY MEMBER	NAME	AGE	HIGHEST LEVEL OF EDUCATION	OCCUPATION
Father				
Mother				
Sibling(s)				

***EMERGENCY CONTACT** _____ **Phone** _____

PRESENTING CIRCUMSTANCE(S)
(Why are you here?)

1. _____
2. _____
3. _____

ARE YOUR CURRENT CIRCUMSTANCE(S) INTERRING WITH YOUR ACADEMIC PERFORMANCE?

ARE YOUR SOCIAL RELATIONSHIPS BEING AFFECTED YOUR CURRENT CIRCUMSTANCE(S)?

ARE YOU MISSING CLASS BECAUSE OF YOUR CURRENT CIRCUMSTANCE(S)?

IS YOUR CURRENT CIRCUMSTANCE(S) SO OVERWHELMING THAT YOU HAVE CONSIDERED WITHDRAWING FROM COLLEGE?

WHAT WOULD YOU LIKE TO LEARN THAT COULD HELP YOU WITH THE PROBLEM(S)? CHECK ALL THAT APPLY.

☐ what is creating my problems
☐ more about myself
☐ how to feel better
☐ other _____
☐ how to respond differently to problems, issues, etc.
☐ how to cope with feelings/situation
☐ I have no idea

SEXUAL ORIENTATION _____

RELIGIOUS BELIEFS _____

POLITICAL BELIEFS _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or, that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐

If you have 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

DASS 21 NAME _____ DATE _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement. *The rating scale is as follows:*

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

FOR OFFICE USE

	N	S	O	AA	D	A	S
I found it hard to wind down	☐	☐	☐	☐			
I was aware of dryness of my mouth	☐	☐	☐	☐			
I couldn't seem to experience any positive feeling at all	☐	☐	☐	☐			
I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	☐	☐	☐	☐			
I found it difficult to work up the initiative to do things	☐	☐	☐	☐			
I tended to over-react to situations	☐	☐	☐	☐			
I experienced trembling (eg, in the hands)	☐	☐	☐	☐			
I felt that I was using a lot of nervous energy	☐	☐	☐	☐			
I was worried about situations in which I might panic and make a fool of myself	☐	☐	☐	☐			
I felt that I had nothing to look forward to	☐	☐	☐	☐			
I found myself getting agitated	☐	☐	☐	☐			
I found it difficult to relax	☐	☐	☐	☐			
I felt down-hearted and blue	☐	☐	☐	☐			
I was intolerant of anything that kept me from getting on with what I was doing	☐	☐	☐	☐			
I felt I was close to panic	☐	☐	☐	☐			
I was unable to become enthusiastic about anything	☐	☐	☐	☐			
I felt I wasn't worth much as a person	☐	☐	☐	☐			
I felt that I was rather touchy	☐	☐	☐	☐			
I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	☐	☐	☐	☐			
I felt scared without any good reason	☐	☐	☐	☐			
I felt that life was meaningless	☐	☐	☐	☐			
TOTALS							

PLEASE CHECK (✓) FROM THE LIST BELOW, WHICH PROBLEMS YOU ARE CURRENTLY FACING:

- ☐ How to study effectively
- ☐ Not spending enough time in study
- ☐ Fear failure in college
- ☐ Worry about poor grades
- ☐ Doubt my vocational choice
- ☐ Purpose of going to college unclear
- ☐ Undecided major

- ☐ Ill at ease with others
- ☐ Feel no one understands me
- ☐ A problem difficult to talk about
- ☐ Hurting feelings of others
- ☐ Sometimes acting childish/immature
- ☐ Lack self-confidence
- ☐ Worry about unimportant things
- ☐ Nervousness
- ☐ Often experience panic feelings

- ☐ Being lazy
- ☐ Feel inferior
- ☐ Not the kind of person I should be
- ☐ Too easily hurt

- ☐ Troubled/Guilty conscience
- ☐ Afraid of making mistakes
- ☐ Unhappy home life
- ☐ Getting along with family member(s)

- ☐ Financial problems
- ☐ Feelings of extreme loneliness
- ☐ Easily/Frequently become depressed
- ☐ Thinking of suicide

- ☐ Worry about how much I drink
- ☐ Worry about my drug use
- ☐ Often weak/exhausted
- ☐ Bothered by nightmares
- ☐ Difficulty controlling how I eat

- ☐ Too inhibited in sexual matters
- ☐ Worry about my sexuality
- ☐ Sexual needs unsatisfied
- ☐ Troubled by sexual experience(s) when younger
- ☐ Fearful of/avoid members of opposite sex
- ☐ Problems with girl/boy friend

- ☐ End of love relationship
- ☐ Shoving/Hitting girl/boyfriend
- ☐ Fearful of close relationships with others
- ☐ Roommate problem

- ☐ Being talked about/watched
- ☐ Bothered by unwanted/disturbing thoughts
- ☐ Hearing/Seeing unusual things

- ☐ Angry/Hostile feeling toward other(s)
- ☐ Losing my temper
- ☐ Injuring myself
- ☐ Injuring others
- ☐ Fighting/Assaulting others

- ☐ Other _____

_____

_____

_____

_____ _____

Signature Date

AUSTIN COLLEGE | Counseling Services

LIMITED RELEASE OF INFORMATION

CLIENT _____ DOB _____

I, _____, hereby authorize Austin College Counseling Services to RELEASE OR RECEIVE medical and mental health treatment information and/or records regarding diagnosis and treatment, for the purpose of coordination of care between providers and others involved in my treatment.

RELEASE TO/RECEIVE FROM _____
(EX: REFERRING PHYSICIAN, RELATIVE, ATTORNEY, ETC.)

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by email

I understand that electronic mail (email) is not confidential and can be intercepted and read by other people.

Information to be released: ☐ Attendance/Dates of service ☐ Diagnosis ☐ Treatment plan/goals
☐ Treatment Summary ☐ Other _____

Is there any medical/mental health information that you do not wish to be released? ☐ Yes ☐ No
If so, what?

- I understand that I have a right to receive a copy of this authorization.
- I understand that any cancellation, modification, or revocation of this authorization must be in writing.
- I understand that I have the right to revoke this authorization at any time unless Austin College Counseling Services has taken action in reliance upon it.
- I understand that it is my responsibility to confirm receipt by Austin College Counseling Services of any cancellation, modification, or revocation.
- I understand that Austin College Counseling Services shall not condition treatment upon the signing of this authorization and that I have the right to refuse to sign this form.
- I understand that refusing to sign this form does not stop disclosure of health information that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities (referring physicians, other clinical staff/treatment team members at AC Counseling Services, and other medical/mental health professionals referred to me by AC Counseling Services) as provided by Texas Health & Safety Code § 181.154© and/or 45 C.F.R § 164.502(a)(1).
- I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Texas law may protect such information. In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

I, _____ CONSENT to the release of information _____
(Signature of client) (Date)

EFFECTIVE TIME PERIOD. This authorization is valid for 1 year from the date signed unless another date is specified below.

Only complete this box if you wish to withdraw permission to release information.

I, _____, wish to withdraw my consent to release information on _____.
(Signature of client) (Date)

Submit