



JCHS Counseling Department

Student Information Form

Name: _____

Date: _____

Major reason you are currently seeking counseling? _____

If not self-referred, who referred you for counseling services? _____

Do you give your permission to let the above-named faculty/staff member know that you saw a counselor? Yes _____ No _____

Have you been seen by a counselor before at the Jefferson College of Health Sciences?

Yes _____ No _____

Employment Status:

Where? _____

Shift (1st, 2nd, 3rd) _____

Part-Time 1-9 hours per week _____

Part-Time 30-39 hours per week _____

Part-Time 10-19 hours per week _____

Full-Time 40 or more hours per week _____

Part-Time 10-29 hours per week _____

Not employed _____

You are not required to answer the following questions regarding disabilities but you are encouraged to disclose this information especially if you expect/need accommodations. Have you ever been diagnosed with a disability that interferes with learning? _____

If yes, please circle all that apply:

Learning Disability

Neurological Impairment

Speech Impairment

Hearing Impairment

Mental/Emotional Illness

Orthopedic Impairment

Temporary Disability

ADD/ADHD

Medical Impairment

Visual Impairment

Any history of academic difficulties? No Yes, please explain _____

Please circle the following issues that are a problem for you:

Depression

Nervousness

Weight gain/loss

Loss of Family

Concentration

Impulsive

Member

Temper outburst

Legal problems

Sadness

Anger control

Health problems

Suicidal Thoughts

Difficulties with

Marital problems

Shyness

friends

Eating problems

Sleep Difficulties

Isolation

Loneliness

Lack of Motivation

Relationships

Nightmares

Self-esteem issues

Obsessive thinking

Extreme Fears

Anxiety Attacks

Sexual abuse

Underachievement

Please circle below the extent that these problems are interfering with your academic performance?

- | | | | | | |
|------|----------|-------------------|-------|----------|------------|
| 0 | 1 | 2 | 3 | 4 | 5 |
| None | A little | A moderate amount | A lot | Severely | Profoundly |

Please add any additional information you think would be helpful for me to know:

Date

Signature



JEFFERSON COLLEGE
of HEALTH SCIENCES

**Jefferson College of Health Sciences
Counseling Office**

Notice of Privacy Practices

I. Confidentiality:

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality:"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, some because of policies at JCHS, and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and consent to accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- **Emergency** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services.
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.
- **Health Oversight:** Virginia law requires that I report misconduct by a mental health care provider of my own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make a report to the licensing board. If you are yourself a health care provider, I am required by law to report to your licensing board if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records for investigating a complaint of provider incompetence or misconduct.

· **Court Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so that you (or your attorney, or I) can file a motion to quash (block) the subpoena and can give reasons why I think your records should be protected from disclosure. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. NOTE: In Virginia civil court cases, therapy information or records are not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue (e.g., if you sue someone for mental/emotional damages), or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

· **Serious Threat to Health or Safety:** Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, (2) notifying a law enforcement officer, or (3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian *ad litem*, a CSB evaluator, or law enforcement officer, whether you are a minor or an adult.

· **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· **Records of Minors:** Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

· **Right to Request Restrictions-**You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: (1) what information you want to limit; (2) whether you want to limit my use, disclosure or both; and (3) to whom you want the limits to apply.

· **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations -** You have the right to request and receive confidential communications by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your letter to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· **Right to Amend** - If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· **Right to a copy of this notice** - You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

Effective Date: _____

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of the JCHS Counseling Department's Notice of Privacy Practices. We have discussed these policies, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services.

Signature: _____

Printed Name: _____

Date: _____