



What are Recommendation and Referral Services (R & R)

Recommendation and Referral hours provide an opportunity for a brief consultation to help determine appropriate services within CHWS, referrals to other supports, and/or next steps based upon current distress, presenting concerns, and availability of services. The goal of R & R is to evaluate what might best meet your therapeutic needs and provide a path towards that service. R & R may also help to resolve small issues that only require one session to complete.

CHWS is able to provide weekly group therapy and limited individual therapy. If you believe weekly therapy would best suit your needs please discuss referral options with your R & R counselor.

In cases of emergency, students should contact Security Services at 253.879.3311 or ext. 3311 from a campus phone, or call 911 if off campus.

What this service *is not*

- A thorough psychological assessment (i.e., “intake appointment”)
- Designed to provide quick answers for more complex questions or issues
- Sufficient to provide documentation for accommodations, study abroad, or medical withdrawal

Services outside our scope of practice

Counseling, Health, & Wellness Services provides outpatient treatment for a range of psychological conditions; however, we are *not* equipped to provide intensive or long-term care. If it is determined that we do not have the appropriate resources to meet your treatment needs, our treatment approaches are not proving effective, or we have reached capacity, we may refer you to appropriate providers outside the college. Examples of issues where referral *may* be necessary include but are not limited to: *history of multiple hospitalizations, chronic suicidality and/or self-harming behaviors, history of repeated suicide attempts, severity of alcohol or drug use that requires intensive outpatient or inpatient treatment, severity of an eating disorder that requires intensive outpatient or inpatient treatment, evidence of progressive deterioration in ability to function, need for formal psychological evaluation, and assessment of learning disability/ADHD or neuropsychological testing. Court-mandated assessments or treatment are not provided by CHWS.*

By signing below you acknowledge having read and understood the above. If you have questions about this information, please ask your counselor before consenting.

Your name (print): _____

Signature: _____ Date: _____

Recommendation and Referral Questionnaire

Please complete the following information to help us support you in getting the most out of this screening and to assist you with coordinating care:

Today's Date _____ Name _____ Age _____

Birth Date _____ Gender _____ Pronouns _____

Race / Ethnicity (ies) _____ Country of Origin _____

Sexual Orientation _____ Relationship Status _____

Year: First ____ Second ____ Third ____ Fourth ____ Fifth+ ____ Grad student ____

Major _____ Minor _____

Are you coming in to seek advice about how to support another student? Yes No If yes, stop here.

Are you coming in to seek help for yourself Yes No If yes, complete the remainder of this form.

Are you covered by medical insurance? Yes No Not sure

If so, is there any hesitation to using it? _____

Are you currently working with a therapist (either local or at home)? Yes No

If so, are you hoping to change therapists? Yes No

If so, please offer some additional context: _____

In your own words, briefly describe why you have come to CHWS today:

Which of our on-campus groups might address your concerns:

- Check yourself before you wreck yourself-come discuss challenges and struggles get support from others.
- Between the Lines LGBTQA-Social and Emotional support for lesbian, gay, bisexual, transgender, queer, Intersex and asexual students.
- Life Hacking Skills – 12 week series that helps people learn to manage life more effectively – Depression/Anxiety/Trauma
- All Addictions Anonymous (AAA)- 12 step group for all compulsive issues and concerns
- Sexual Assault Survivors Group- A safe environment for recovery from sexual abuse or assault.

Has anyone you have known committed suicide? Yes No Relationship to you: _____

As a child or adult, have you experienced any of the following? Mark all that apply:

- Yes No Physical Abuse
- Yes No Sexual Abuse
- Yes No Homelessness
- Yes No Emotional Abuse
- Yes No Domestic Violence
- Yes No Interpersonal Violence
- Yes No Bullying or Oppression
- Yes No Food Insecurity

Check the statement that best describes your status:

_____ I am basically getting along OK, but feel I could use help sorting things out or doing things differently.

_____ I am experiencing serious emotional difficulty that is negatively affecting most or all parts of my life.

_____ I am feeling suicidal.

Who, if anyone, referred you to CHWS? _____. If this person inquires about your contact with CHWS, do we have your permission to acknowledge that you have been seen? (If you authorize this release of information, we would only confirm that you were seen in CHWS.)

YES _____ NO _____ _____

Signature

Date



Counseling, Health,
& Wellness Services

1500 North Warner St. CMB #1035, Tacoma, WA 98416-1035
PH: 253-879-1555 * Fax: 253-879-3766

Notice of Privacy Practices

To our patients and clients: As required by the Health Insurance Portability and Accountability Act of 1996, this notice describes how health information about you, as a patient or client of this practice, may be used and disclosed and how you can access your health information.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining your privacy. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated so we must provide you with the following important information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your “Protected Health Information” (PHI) without your authorization:

1. To public health authorities and health oversight agencies that are authorized by State and Federal law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official in order to comply with a court order or subpoena.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs if you file for these benefits.

Your Rights Regarding Your Protected Health Information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We attempt to accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including treatment and billing records. You must submit your request in writing to Director of Counseling, Health, & Wellness Services (CHWS) at the University of Puget Sound (telephone 253.879.1555).
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To amend your record, your request must be made in writing and submitted to Director of CHWS at the University of Puget Sound (telephone 253.879.1555). You must provide a rationale supporting your request for amendment.
5. Right to a copy of this notice. You are entitled to a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy, contact CHWS at 253.879.1555 or write to chws@pugetsound.edu.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice. To do so, contact Director of CHWS at 253.879.1555. Formal complaints must be submitted in writing. You will not be penalized for filing a complaint. Alternatively, you may file a complaint with the State of Washington Department of Health, Health Systems Quality Assurance, P.O. Box 47857, Olympia, WA 98504-7869, 360.236.4700.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this Notice, or about our health information privacy policies, please contact the Director of CHWS at the University of Puget Sound at 253.879.1555.

I hereby acknowledge that I have been presented with a copy of the University of Puget Sound's Counseling, Health, & Wellness Services' Notice of Privacy Practices.

Signature

Date Signed

Printed Name

Rev 11.19 EP



Informed Consent to Treatment for Counseling Services

Please *read* the following information, *ask* any questions, and *sign* both copies of this document. Your signature acknowledges that you have read and understand the information below.

Scope of Counseling Services Based on the recommendation consultation students and providers collaborate to determine best treatment options. These might include short-term counseling in CHWS (group or individual treatments), use of our online support website TAO, referral to off-campus providers or a combination of resources.

Rights in the Counseling Process Federal laws, the Washington Administrative Code, the Revised Code of Washington, and the Ethical Code of the American Psychological Association guarantee these rights to all people engaged in activities related to the practice of psychology:

Privacy (Confidentiality) Information shared during counseling sessions is confidential. As allowed by law, your provider may consult with other health care professionals regarding your care. If you are being seen by a Psychology Intern or a Practicum Counselor, that counselor will be closely supervised by a Staff Psychologist who will be kept apprised of your progress, and will direct treatment planning.

Information ordinarily will not be disclosed outside of CHWS without your written permission. However, there are exceptions to this rule by Washington State law. As may be needed to protect the safety of yourself and others, as allowed under Washington State Law, we are obligated by law to break confidentiality. If we suspect or learn of abuse or neglect of a child or vulnerable adult, we may be legally obligated to report that information. If your records are subpoenaed by a court, we may be required to comply with that order. We are required to report ourselves or another health care provider to the Department of Health in the event of a determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if we have actual knowledge of unprofessional conduct.

Records We maintain electronic records of services provided. This record of services is integrated with records of medical services provided in CHWS, thus, is accessible to all CHWS providers. We will not disclose your treatment record to others unless you direct us, or unless the law authorizes/compels us to do so, as described above. You may ask to see a copy of your health care record. In such cases, your provider will usually review the record with you. While CHWS has 30 days to respond to request you may get the information sooner.

Release of Information Information about assessment and treatment can be released to third parties when you sign an authorization to release information. You may rescind an authorization to release information in writing at any time.

Appropriate Care Your participation in mental health treatment at CHWS is voluntary and you have the right to these considerations: The right to be treated with dignity and respect, the right to receive care that is non-discriminatory, and the right to receive care from qualified staff.

Referral Should you prefer to receive psychological services from someone other than the provider you have been assigned, you have the right to request a referral.

Risks of Treatment When receiving mental health treatment there are potential risks given the nature of sharing very personal and private information with your provider. These risks may include general discomfort or experiencing strong emotions or feelings, which can be part of the therapeutic process. This is normal and can be discussed with your provider at any time.

The Right to Conclude Treatment You have the right to conclude treatment at any time. If you have not had a session or made contact with your counselor within 45 days, your file may be closed. If you are in need of continuing treatment services, you may return to our recommendation and referral services at anytime.

Appointments Mental health treatment is initiated in CHWS by making a same day or next day 45 minute appointment to meet with a counselor as part of our recommendation and referral process. Any subsequent individual sessions are usually 50 minutes in length. Group sessions are 60-90 minutes in length. If an appointment time is reserved for you, please provide CHWS with 24 hours' notice if you need to cancel/reschedule to allow the hour to be opened for another student. If you miss an appointment but wish to continue, contact the front desk or your provider to reschedule.

Charges There is no charge for regular counseling services provided by CHWS. Fees are assessed for missed appointments (described below). Fees are charged for some specialized assessments, including mandated substance abuse. These fees are specified in the paperwork you receive when referred for a specialized assessment. Fees for appointments with the CHWS psychiatrist are \$65 for a 30 minute session and \$40 for a 50 minute session.

No-Show Fees Failure to cancel an appointment within 24 hours' notice will result in a \$25 charge for individual and group counseling appointments, \$50 for a 30 minute psychiatry appointment, and \$100 for a 50 minute psychiatry appointment. If you received a charge in error, or there are extenuating circumstances to explain your missed appointment, you may appeal the charge by contacting the CHWS Director.

Ethical Conduct and Professional Standards If you have concerns about your treatment, you are encouraged to discuss them with your provider. Should you have reason to think your provider is practicing unethically, you may discuss the matter with the CHWS Director. You may also direct a letter of concern to the State of Washington Department of Health, Health Systems Quality Assurance, P.O. Box 47857, Olympia, WA 98504-7869, (360) 236-4700.

Summary of Staff Training Senior Psychology Staff are licensed psychologists. Our Doctoral Psychology Interns have completed their PhD or PsyD coursework and are in a final year of clinical training. Practicum Counselors are pursuing graduate degrees in counseling or psychology. Trainees provide treatment under the supervision of senior staff.

Recording Counseling, Health, & Wellness is a training site. Counseling sessions may be video and/or audio recorded by some of our staff. These recordings will be used as training tools to ensure provision of high quality service. Recording will be discussed more fully with your clinician. If you are not open to recording your clinician will discuss referral to off campus services.

In Case of Emergency If you require emergency psychological care during our business hours (Monday-Friday, 8am-noon and 1-5pm) you can contact CHWS directly at (253) 879-1555. When CHWS is closed, you should contact Security Services at (253) 879-3311 if you are on campus or 911 if you are off campus. You may also contact the 24-hour Pierce County Crisis Line at 1-800-576-7764 or the National Suicide Prevention Lifeline at 1-800-273-8255.

Contacting CHWS Providers You may contact your provider via the secure CHWS communication portal at www.my.pugetsound.edu. We discourage clients from using email to communicate about personal concerns, and we will respond to any such emails via the portal. Do not use email, voicemail, or the portal for crises or emergencies.

Social Media and Telecommunications Due to the importance of your confidentiality and maintaining appropriate boundaries of a therapeutic relationship, CHWS providers do not accept friend requests or contact requests from current or former clients on any social media platform (Facebook, Twitter, LinkedIn, etc). Similarly, CHWS providers do not conduct therapy over Skype or other like platforms.

I have read and understand the information provided in this document about my rights and responsibilities while working with Counseling, Health, & Wellness Services.

Client Name (print)

Signature

Date

Provider Name (print)

Signature

Date



Counseling, Health, & Wellness Services

**Credential Disclosure
 2019-2020**

Below you will see a check mark by the name of your therapist, along with their title and credentials. If your therapist is a supervisee or unlicensed counselor, the name of their supervisor(s) is (are) also listed.

| Supervisee | Supervisor |
|--|--|
| <input type="checkbox"/> Erin Potts, Psy.D. | <input type="checkbox"/> Kelly Brown, Ph.D. (License# 60236263) |
| <input type="checkbox"/> Kendal Cassidy, MA | <input type="checkbox"/> Charee Boulter, Ph.D. (License# 2334) |
| <input type="checkbox"/> Alexandra Emery, MA | <input type="checkbox"/> Khalila Fordham, Psy.D.(License#60836125) |
| <input type="checkbox"/> Megan Martinez, BA | <input type="checkbox"/> Erin Potts, Psy.D. |
| <input type="checkbox"/> Ellie Lisitsa, MA | <input type="checkbox"/> Kendal Cassidy, MA |
| <input type="checkbox"/> Emily Peterman Cabano, MA, MS | <input type="checkbox"/> Alexandra Emery, MA |
| <input type="checkbox"/> Brent Hopkins, Ph.D. | <input type="checkbox"/> Megan Martinez, BA |
| | |
| | |

Your signature below indicates that you have been informed of the name, title, and credentials of your counselor. If your counselor is a supervisee you also have been informed of the name, title, and credentials of their clinical supervisor(s).

NAME _____ **DATE** _____
 (Please print)

SIGNATURE _____



Authorization to Record Counseling Sessions

Counseling, Health & Wellness is a training site. Counseling sessions will be recorded by some of our staff. These recording will be used as training tools to ensure provision of high quality service.

Who might ask me to record my counseling sessions?

Any counselor may ask to record your sessions. We have counselors completing their final year of training in Clinical or Counseling Psychology before receiving their doctorates, called Psychology Interns. We also have students who are in training to become Counselors or Psychologists, called Practicum Counselors. Both Interns and Practicum Counselors have a supervisor who routinely reviews their work, thus they are most likely to ask to record sessions.

Why would my counselor ask my permission to record?

- (1) *For quality assurance:* To guarantee that Puget Sound students are getting the most skilled and ethical psychotherapy possible.
- (2) *For treatment excellence:* To add the perspective of another professional.
- (3) *For training:* We commit to providing trainees the highest quality supervision. Supervisors can give the most specific, meaningful feedback by observing recorded sessions.

Why me?

Reviewing recorded sessions is an expected part of the training to become a Psychologist and is common practice at most university counseling centers.

Who would review the recording?

Only members of the CHWS Psychology staff will review your recordings; all members of the Psychology staff hold recordings to the highest level of confidentiality. Typically only your provider and his/her/their supervisor will review your recordings.

How are the recordings protected?

Recordings are stored on a protected drive that can only be accessed by Psychology staff. We delete the recordings within 2 weeks of the session. Recordings are reviewed in CHWS.

If you chose NOT to be recorded.

Your clinician will assist you with off campus referrals.

Consent to Record Counseling

I authorize recording of one or more sessions at CHWS. I understand recording is for the purposes of quality assurance, treatment excellence and training.

I give this authorization with the assurance that recording will be handled in a professional, confidential manner in accordance with the American Psychological Association's ethical guidelines.

I realize that I have the right to withdraw my consent for recording at any time. If so, your provider can assist with off campus referrals.

Student name (print): _____

Student signature: _____

Date: _____

Informed consent for telehealth sessions

1. I understand that “telehealth” includes secure videoconferencing, secure messaging, and telephone conversations using interactive audio, video, or data communications.
2. Unless I explicitly provide agreement otherwise, telehealth exchanges are strictly confidential. Any information I choose to share with my provider will be held in the strictest confidence. My private information will not be released by CHWS unless it is required by law, as you were informed in the CHWS Informed Consent to Treatment for Counseling Services, the Agreement to Treat for Medical Services, and the Privacy Practices.
3. I understand that if I participate in a group format service that I will take reasonable steps to ensure privacy for myself and others by selecting a private location in which I will not be disturbed. I understand that there are additional limitations to the confidentiality of the content I discuss with my peers. Also, if I agree to participate in a group, I agree not to release the personal identity or information of any group members without their permission.
4. I understand that telehealth services will be only be available during the time that has been scheduled for the client/patient and the provider.
5. I understand that I have the right to withdraw or withhold consent for telehealth services at any time. I also have the right to terminate treatment at any time.
6. Cost for telemedicine medical services will be \$20 per visit. This fee will be transferred to your student account. Prescriptions will be sent to a local pharmacy for patient pick up.
7. While telehealth will be conducted primarily through secure and private videoconferencing, I understand that there are always some risks with telehealth services including, but not limited to, the possibility that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.
8. I will work with my provider to identify an alternative communication method (most often phone) in the event that the videoconferencing tool fails.
9. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.
10. I understand and accept that telehealth does not provide emergency services. If I am experiencing an emergency, I understand that the protocol would be **to call 911 or proceed to the nearest hospital emergency room for help. If I am experiencing suicidal thoughts or making plans to harm myself, I may call the National Suicide Prevention**

Lifeline at 1- 800-273-TALK (8255) or the Pierce County Crisis Line at 1-800-576-7764 for free 24-hour hotline support.

11. I will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access to participate in telehealth sessions, (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions.
12. I agree not to record telehealth sessions.
13. I agree to be dressed as if I were attending an in-person face to face session.
14. I have the right to access my medical and/or counseling information and copies of my records in accordance with HIPAA privacy rules and applicable state law.
15. I understand that services delivered by my CHWS provider are required by law to take place within the state of Washington, as the CHWS providers are licensed in Washington. There may on rare occasions be an exception for crisis consultations or to assist with out of state referrals for continuity of care. If I am physically located outside of the state of Washington I will immediately notify my CHWS provider. I understand my CHWS provider will refer me to locate support and resources within the state I am located.
16. I understand that my CHWS provider may attempt to call me by phone if during a videoconference there is a technology failure. My CHWS provider may attempt to call me by phone if I do not show for a scheduled video conference. In addition, if you are showing signs of being in a medical or mental health crisis/emergency, CHWS requires that we have permission to contact someone to ensure your safety. We require three levels of contacts:

- 1) a close personal contact such as a parent, partner, or spouse

Personal Contact:

Name: _____ Relationship: _____

Phone: _____

- 2) professional contact such as a student affairs professional, a residence hall director, or a personal physician

Professional contact:

Name: _____ Relationship: _____

Phone: _____

- 3) The office or Agency that does crisis well-being checks in your community (typically a 24-hour crisis service or the police department).

Crisis response: _____

My physical address is: _____

Signature of patient/client is required below or you may reply to a secure message indicating you agree to this informed consent and in your reply provide CHWS with the three listed emergency contacts.

Print name: _____

Date: _____