YORK COUNTY COMMUNITY COLLEGE
COUNSELING
INFORMED CONSENT AGREEMENT

SERVICES OFFERED: Acute (semester long) Psychotherapy Services, Group Therapy, Referrals. We will discuss other referral and treatment recommendations with you.

MUTUAL RESPECT: The Counselor is committed to respecting those with whom they work and expect students in turn to behave in a respectful manner with the Counselor and any staff. Threatening or abusive language may result in termination of services with a referral to the Dean of Students for follow-up. Physical violence will not be tolerated.

CONFIDENTIALITY: Information shared in counseling sessions will be handled confidentially for all adult clients. The exceptions to the rule of confidentiality include the following:

1) If there is reason to believe you might be in imminent danger of harming yourself or others: if so, the appropriate authorities may be contacted (police, administrator, campus security, YCCC BIT Team (Behavioral Intervention Team));

2) If there is reason to believe that a child or vulnerable adult has been, or is likely to be, abused or neglected;

3) If there is a valid court order which requires disclosure of information; and/or

4) You provide written permission to release information.

5) You have the opportunity to opt into appointment reminders sent out by the student success coordinator who will know your name and that you attend counseling, but will not have access to other confidential information. If you would like to opt into appointment reminders you agree to the student success coordinator having access to your name and email and being aware that you attend counseling.

☐ I agree and want appointment reminders or

☐ I do not agree and do not want appointment reminders.

RECORDS: Personal data and records of the services you receive will be stored securely. A counselor's notes and any other written information regarding your contact with Counseling are maintained separate and apart from your college academic record. Counseling files are maintained on campus for a fixed period of time after graduation and then destroyed. With your written authorization, counseling information can be disclosed to a third party for the specific purpose stated in your authorization. You may request to review your counseling records by filing a written authorization with Counseling. Your request will be responded to within a reasonable period of time. If Counseling staff believe that review of these records would be detrimental to your health or well-being, Counseling reserves the right to require that a member of Counseling staff be present while you review the file in order to discuss or help interpret information contained in the file.

E-MAIL AND PHONE POLICY: Email is not a secure means to transmit confidential information. Because confidentiality cannot be ensured, and because of our belief in the importance of face-to-face contact, general therapy concerns should be discussed in person with your counselor. However, scheduling appointments can be made by phone and with your consent, by email.

I have read and understood this agreement.

Student Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

(If under 18 years of age)

Counselor Signature: _____ Date: _____

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York County Community College

Mental Health Intake Form

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your counselor. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION Date: _____

Last Name: _____ **First Name**: _____**MI**____

Street Address: _____Apt or Box #:_____

City_____State_____ZIP_____ County_____

Home Phone Number (_____) _____Cell Phone (_____) _____,

email address: _____

Work Phone Number (_____) _____ Date of Birth___/___/_____

Gender ☐ Male ☐ Female, ☐ Transgender ☐ Self Describe _____

Referred by: ☐ Self-Family/Friend ☐ School ☐ Physician

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐ Other_____

Ethnicity: ☐ White/Caucasian ☐ African American ☐ Hispanic ☐ American Indian

☐ Asian/Pacific Islander ☐ Other: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed/looking for work ☐ Student ☐Retired ☐ Disabled ☐ Other: _____

Emergency Contact: _____

Relationship to Client: _____ Phone: _____

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SECTION II: FAMILY/HOME INFORMATION

How many dependents do you have? (Include yourself)_____

Children	Age	Living at Home?

List other people living in the home besides those named above:

Name	Age	Relationship

Are your parents divorced? Yes☐ No☐

Have any members of your family had problems with: Drugs☐ Alcohol☐ Mental Illness☐

SECTION III: DESCRIPTION OF PRESENTING PROBLEM

Briefly describe the problem that brings you to counseling services today:

_____

_____

_____

How can we help you with this, what do you want to work on in counseling and change?

_____

_____

_____

How long has it been a significant problem?

_____

In the past, what has been helpful to you in dealing with this problem?

_____

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How would you estimate the severity of the problem: Mild☐ Moderate☐ Serious☐ Severe☐ ?

SECTION IV: MEDICAL/HEALTH INFORMATION

Treatment History:

Have you received mental health treatment before? ☐ Yes ☐ No

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please give dates of treatments and results:

Therapist/Hospital	Dates	Phone	Initial Reason	Outcome

Please check any of the following that you have experienced recently:

☐ Depression	☐ Anxiety	☐ Voices/visions	☐ Suicide
☐ Panic attacks	☐ Running away	☐ Appetite problems	☐ Stealing
☐ Compulsive behaviors	☐ Weight loss/gain	☐ Racing thoughts	☐ Paranoia
☐ Sleep problems	☐ Too much energy	☐ Poor attention	☐ Anger
☐ Social Withdrawal	☐ Distractibility	☐ Irritability	☐ Low energy
☐ Aggression/violence	☐ Poor concentration	☐ Hyperactivity	☐ Blackouts
☐ Memory problems	☐ other(s) _____		

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It is very important for your counseling treatment that we are able to have contact with your primary care provider (PCP). Do you give your permission for us to contact your PCP? ☐ Yes ☐ No

If you decline, please provide specific information for your denial:

_____

Who is your primary doctor/medical provider?

_____

Name City Phone number

What medications do you take? (Include non-prescription, herbal medicines and supplements)

Medicine Dose Frequency Who prescribes

_____ _____

_____

_____

_____ _____

Please list any allergies, including medication allergies/sensitivities:

_____

Date of your last exam: _____

Please list any significant health or medical or psychiatric issues, including any resulting in hospitalization

Dates Problem and Treatment Were you hospitalized Y/N

_____

_____

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Suicide Attempt/s or Violent Behavior:

Age Reason Circumstance How

_____

_____

Abuse/Trauma History: ☐ I was not abused in any way ☐ I was abused

If you were abused, please complete this section. . To describe the type of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Substance Use:

Have you been treated for alcohol/drug problems before? ☐ Yes ☐ No

If so, when and

where_____

Check any of the following that apply to you:

	Never	**Rarely**	**Frequently**	**Very Often**
Marijuana	☐	☐	☐	☐
Tranquilizers, benzo's	☐	☐	☐	☐
Sedatives	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐
Cocaine/crack/ ecstasy/bath salt/Meth	☐	☐	☐	☐

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	Never	Rarely	Frequently	Very Often
Painkillers, oxys, opiates	☐	☐	☐	☐
Heroin	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Stimulants Adderall	☐	☐	☐	☐
Hallucinogens LSD/Mushroom /PCP	☐	☐	☐	☐
Compulsive Exercise	☐	☐	☐	☐
Use Laxatives	☐	☐	☐	☐
Heroin	☐	☐	☐	☐
Inhalants	☐	☐	☐	☐
Synthetic Cannabis (spice)	☐	☐	☐	☐
Sleeping pills	☐	☐	☐	☐
Muscle Relaxer	☐	☐	☐	☐
Other	☐	☐	☐	☐

Alcohol Use:

Have you ever felt the need to cut down on your drinking? ☐No ☐Yes

Have you ever felt annoyed by criticism of your drinking? ☐No ☐Yes

Have you ever felt guilty about your drinking? ☐No ☐Yes

Have you ever taken a morning "eye-opener"? ☐No ☐Yes

How much beer, wine, or hard liquor do you consume each week, on average?

How much tobacco do you smoke or chew each day?

Describe any problems associated with these substances that you have experienced.

_____
_____
_____
_____

How much time outside of academic work do you spend on the internet per day?

_____

SECTION V: SOCIAL RELATIONSHIP STATUS

Among friends and family who do you depend on for support?

_____

Are you: Single____Dating____Married/Partnered____Divorced/unpartnered____Widowed/ a surviving partner____

Friendships, Community and Spirituality – describe quality, frequency, activities

_____
_____
_____

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce/custody disputes? If yes, please explain:

_____
_____
_____

What gives you the most joy or pleasure in your life?

_____
_____
_____
_____

What are your main worries and fears?

_____
_____
_____
_____
_____

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What are your most important hopes and dreams?

_____
_____
_____
_____

Is there anything else we need to know to assist you?

York County Community College, Student Counseling Services
112 College Drive, Wells, Maine 04090

Name: _____
Address: _____

Telephone: _____

DOB: _____ _____

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AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION

I hereby authorize, by my initials, YCCC Counseling, or its authorized employees or agents, to release and/or obtain the following specified information by means other than Fax. I understand that my Counseling records may contain reference to sensitive or statutorily protected information that will not be released unless I authorize the release of each category:

☐ mental/emotional health, including antidepressant medications

☐ abortion ☐ sexual abuse/assault ☐ sexual preference

☐ drug/alcohol abuse ☐ HIV/AIDS

I hereby authorize the above initialed information to be released to and/or obtained from the following:

Release to: *and/or* Obtain from:

Name or Facility _____

Address_____

City/State/Zip _____

Specified Information to Release _____

The purpose of this release is to:

_____

I understand that I may refuse to authorize disclosure of all or some my counseling information and records, and that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance and/or other adverse consequences. I agree to release and hold harmless the Maine Community College System and York County Community College, and their respective officers, employees and agents harmless from any injury, claims and damages that may arise as the result of the release or acquisition of my counseling information and records. This Disclosure Authorization will expire six months from the date of signing, unless otherwise specified herein. I understand that I can revoke this consent at any time before the expiration date by notifying Counseling Services in writing, except to the extent that action has been taken in reliance on my consent. I further understand that if I revoke my consent, such revocation may be the basis for denial of counseling benefits or other insurance coverage or benefits. I understand that I am entitled to a copy of this authorization form.

Signature: _____ Date: _____

_____ With my initials, I acknowledge receipt of a copy of this form.

Parent/Guardian: _____ Date: _____
(If under 18 years of age)

RE-RELEASE OF CONFIDENTIAL COUNSELING INFORMATION BY RECIPIENTS IS PROHIBITED UNLESS AUTHORIZED IN WRITING BY THE CLIENT.