UCA Counseling Center Confidentiality Policy

Confidentiality is an ethical standard that protects clients from the disclosure of information without their consent. Client contacts with the Counseling Center are confidential. We will not provide information about clients to friends, partners, faculty, parents, employers or anyone else outside of the Counseling Center Staff. Information may be exchanged between the UCA Counseling Center, the UCA Student Health Clinic, and Disability Support Services without requiring client consent, when those offices are providing services for the same client.

The Counseling Center will release information from counseling sessions to third parties only at the request of the client. The "Authorization to Release Professional Information" form, signed by the client and a witness, will be used for that purpose. The client must give informed consent and therefore his/her counselor will discuss, prior to release, the information to be released, to whom, and for what purpose. The client will also be advised about the possible effects of disclosure.

Exceptions:

- When the Counseling Center believes that a client poses a clear and present danger of harm to himself/herself and/or others (verbal threat, action, or possession of a prohibited weapon or prohibited device), the Counseling Center may selectively release information, without the client's consent, to aid in the care and protection of the client or endangered others.
- When the Counseling Center has reasonable cause to suspect that a child (a person under 18 years of age) has been subjected to child maltreatment, which may involve abuse, sexual abuse, neglect, sexual exploitation or abandonment as defined by Arkansas Law, the Counseling Center may selectively release information, without the client's consent, to aid in the care and protection of a child. The Counseling Center is further required by Arkansas Law to report this information to the Department of Human Services.
- When the Counseling Center has reasonable cause to suspect that an adult (a person 18 years of age or older) through abuse or neglect, is in imminent risk of death, or bodily harm and does not comprehend the nature and consequence of remaining in that situation or condition, then the Counseling Center is required to report this situation to the Arkansas Department of Human Services.

E-mail Communication:

E-mail is an important means of communication. However, e-mail is not a secure means to transmit confidential information. Therefore, the Counseling Center will use e-mail to communicate with clients only (a) in response to the client's initiation and (b) with the client's consent to send messages to their e-mail address. Copies of e-mail communication between client and counselor will be scanned into the client's file.

Client files:

The Family Educational Rights and Privacy Act of 1974 (FERPA) provides that students records maintained by physicians, psychologists, psychiatrists or other recognized professionals and para-professionals are not educational records. Therefore, client files do not become part of any permanent record at the University, but are the property of the Counseling Center. A client's file is maintained at the Counseling Center for a period of seven (7) years from the date of last contact. A client's file is destroyed after this seven (7) year period.

Clients may review their records in the presence of a Counseling Center staff member, upon written request. The request and fact that a review occurred will be noted in the client's record. Clients may receive copies of their record unless the Counseling Center, upon review, believes disclosure would be detrimental to the client's health or well-being.

The client file of a person who is not a student, including but not limited to, a staff member, faculty member, student's spouse, etc., is not an educational record.

Client session notes are kept and stored electronically and maintained in the client's file. The entire file including client demographic information and other personal information is maintained electronically in a secured server dedicated to the Counseling Center's needs. Compiled information when retrieved is used for summary report purposes and does not identify clients by name.

Disclosure of Client Records:

Arkansas law recognizes the privilege that attaches to the counselor-client and psychologist-client relations. The privilege is extended only to licensed counselors and psychologists. Should the Counseling Center receive a subpoena for client records, university legal counsel will be consulted prior to taking any action. Clients will be notified in advance, if at all possible, of any compliance with a court order, state or federal law that might require disclosure of client records.

Cancellations & Missed Appointments: It is important that the client arrive on time for his/her appointment. If the client is not going to keep a scheduled appointment, (e.g. due to illness, absence from school, no longer wants counseling) we ask that the client call the Counseling
Center and cancel the appointment at least 24 hours in advance at which the time the client will be asked whether or not he/she wants to reschedule.

When a client fails to contact the Counseling Center to cancel an appointment, he/she is considered to be a **"No Show".** Please be considerate in scheduling because that appointment time, reserved by the counselor for you, could be used to serve another client.

Clients, including No Shows, who reschedule but do not attend two consecutive sessions may have their files closed for the semester and not be permitted to return to counseling until the next semester. Clients who arrive more than 15 minutes late for their appointment will be seen or rescheduled at the discretion of the counselor.

Concerns and Complaints: The Counseling Center staff strives to provide counseling that demonstrates respect for every client, treats all with dignity, and is sensitive to the diversity that is present in those whom we serve. If your counselor does not meet these standards in counseling with you then we encourage you to let us know.

First, you may take your concern directly to your counselor and attempt to resolve the issue/s with him/her. If that interaction does not result in a satisfactory solution - or you are uncomfortable speaking directly with your counselor about your concern - then request to speak with the Director of the Counseling Center (501-450-3138; Student Health Center, Suite 327). The Director will arrange a meeting with you to review the issue/s and attempt to find a suitable resolution.

If the Director of the Counseling Center is your counselor and your complaint is about her, you may contact the Vice President for Student Services (501-450-3416; Student Health Center, Suite 210). He will arrange a meeting with you to review the issue/s and attempt to find a suitable resolution.

A detailed description of the intake procedure can be found on our website at www.uca.edu/counseling.

University of
Central Arkans*as*
Counseling Center
201 Donaghey Avenue, Student Health Center, Suite 327
Conway, AR 72035-0001
(501) 450-3138

Informed Consent for Personal Counseling
University of Central Arkansas Counseling Center

I, _____, have voluntarily decided to seek personal counseling from the UCA Counseling Center. I understand the following points about the treatment I will receive:

1) The treatment that I receive is considered confidential. I have been informed about the exceptions to confidentiality and presented with a full copy of the UCA Counseling Center's confidentiality policy.
2) Services are provided by staff members who are licensed psychologists, psychological examiners, and counselors as well as graduate trainees. I will be informed if I am being seen by a graduate trainee as well as the identity of his/her supervisor. Staff member credentials are kept on file and I may request to view those of my counselor.
3) The staff member who provides my personal counseling will offer treatment that is within the scope of his/her competence to provide.
4) Treatment will be based upon the particular issues, concerns, or problems which the staff member and I agree to work on.
5) Treatment goals are therapeutic in nature. If I have issues that have resulted in **court-ordered** counseling, have legal implications, and/or require formal evaluation, then I will be referred to off-campus mental health professionals for relevant services.
6) No formal diagnosis will be made by the staff member.
7) The treatment will consist of methods (strategies, techniques, and interventions) that are generally accepted in the mental health field as appropriate for the problems that I present. When there are limitations or foreseeable harm that could occur with a specific method, the staff member will explain them to me.
8) The staff member believes the proposed treatment can improve my condition and enable me to achieve my goals but he/she cannot guarantee the results.
9) The staff member may recommend that I complete a psychological test/inventory as a component in my treatment. He/she will explain the purposes and uses of the test(s). I may choose whether or not to take them. The staff member will provide an interpretation of the results for any test that I complete.
10) There is no direct charge or cost for treatment services.
11) I, as the client, will not be forced to continue with the proposed treatment. I can choose to discontinue my personal counseling at any time.
12) I have been presented with the "UCA Counseling Center Client Information" sheet that defines other pertinent information about practices and procedures.

Upon consideration of the information presented to me, I authorize the staff member to provide me with personal counseling and to use the methods that he/she believes clinically appropriate. I make this decision to accept the proposed treatment knowingly, voluntarily, and without coercion.

Signed: _____ Date: _____

The Counseling Center is accredited by the International Association of Counseling Services, Inc.

Consent to Audiotape/Video/Observe Counseling Sessions

The Counseling Center, among its functions, serves as a teaching-training center for Masters-level graduate students. Each student is individually supervised by a professional staff member. The supervision, in part, allows us to see that every client is being provided with competent counseling.

You may be assigned to a Masters-level graduate student for your counseling sessions. Audio taping, video recording and live observation of the sessions are a significant component to their training. Therefore, we use this consent form to obtain your permission to audiotape, video and/or observe. Feel free to ask your intake counselor any questions about the purposes of taping and use of the tapes.

____ Yes, you have my permission to audiotape my counseling sessions.

____ Yes, you have my permission to video record my counseling sessions.

____ Yes, you have my permission to have a professional staff member observe my counseling sessions.

I understand that:

- I may withdraw this consent at any time.
- I may request that the tape recorder or video recorder be turned off at any time and may request that the tape or any portion thereof be erased.
- The purpose of taping is for use in training and supervision. The supervisor may listen/view some/all of the tape. The tape will be erased after supervision.
- Tapes are stored in a secure location within the Counseling Center.
- These tapes may not be used for any other purpose without my explicit written permission.
- My receiving counseling services will not be affected if I do not give permission to tape or observe.

_____ No, I would like to discuss this further with my counselor.

_____ _____

Signature Date

_____ After further discussion with my counselor, I hereby give my permission for taping/observing.

_____ Audio Taping _____ Video Recording _____ Observe

_____ _____

Signature Date

UCA Counseling Center

Student Health Center – Suite 327
Conway, AR 72035
(501) 450-3138

CONFIDENTIAL INFORMATION SHEET

DATE:_____ **UCA ID #_____**

NAME _____(_____)
Last First M. Preferred/Nickname (if applicable)

Current Address _____

City _____ State_____Zip_____

Cell Phone _____

Alternate Phone (Whose #?) _____

Home Address (if different) _____

City _____ State _____ Zip_____

Email _____

May we **CONTACT** you at:

Cell Phone? Yes _____ No _____
Alternate Phone? Yes _____ No _____
Email? Yes_____ No _____

May we leave a **MESSAGE** on your:

Cell Phone? Yes _____ No _____
Alternate Phone? Yes _____ No _____

Please circle the times you are **AVAILABLE** to meet with a counselor:

Monday –		**Tuesday** –		**Wednesday** –		**Thursday** –		**Friday** –	
8:00	12:00	8:00	12:00	8:00	12:00	8:00	12:00	8:00	12:00
9:00	1:00	9:00	1:00	9:00	1:00	9:00	1:00	9:00	1:00
10:00	2:00	10:00	2:00	10:00	2:00	10:00	2:00	10:00	2:00
11:00	3:00	11:00	3:00	11:00	3:00	11:00	3:00	11:00	3:00
	4:00		4:00		4:00		4:00		

1. **Gender: _____** 2. **Age:** _____ 3. **Date of Birth:** _____

4. **Race/Ethnic Background:** African-American / Black ____ American Indian or Alaskan Native ____
Asian American / Asian ___ Caucasian / White ___ Hispanic / Latino ____ Native Hawaiian or Pacific Islander ____
Multi Racial ____ Prefer not to answer ____ Self-Identify (please specify): _____

5. **Sexual Orientation:** Bisexual ___ Heterosexual ___ Lesbian/Gay ___ Questioning ___
Self-Identify (please specify): _____

6. **Relationship Status:** Single ___ Married ___ Divorced ____ Engaged ____ Dating ____ Living Together ____
Separated ____ Widowed ____ Self-Identify (please specify): _____

7. **Children:** Yes _____ No_____ How Many _____ Ages: _____

8. **Military:** Active ____ Reserves ____
9. **Branch:** Air Force ____ Army ____ Navy ____ Marines ____ Coast Guard ____
10. **Veteran:** Yes ____ No ____
11. **Military Dependent:** Yes ____ No ____

12. **Classifications:** Freshman ___ Sophomore ___ Junior ___ Senior ___ Graduate Student ___ Faculty ___ Staff ___
Other ___ 13. **Major: _____** 14. **Current GPA: _____**

15. **Are you Currently Employed?** Yes ____ No ____ Average Number of Hours Per Week:_____

16. **Who Referred You To Counseling?** Self ____Faculty ____(Name:_____)
Staff ____ (Name: _____) Student Health Clinic ____ Friend ____ Other ____
If referred by Athletics, is it for a failed drug test? Yes ____ No ____ If yes, date notified of failed test: _____

17. **Did you take the Mental Health Online Screening**? Yes ____ No ____

18. **Previous Counseling Help?** Yes _____ No _____ If yes, name of counselor and/or facility:
_____

19. **Are You Presently Taking Any Medication?** Yes _____ No _____
Prescription? _____
Reason: _____
Prescribed by: Family Doctor ___ Psychiatrist ___ OB/GYN ___ Student Health Clinic ___ Other ___
Over The Counter? _____
Reason: _____

Family Members (Parents and Siblings) / **Significant Others** (Partner and Children):

Relationship (**DO NOT** List Name**)**	Age	Education	Occupation

Please read this list and check the items of concern to you:

_____ 1. Adjustment to college
_____ 2. Academics/Grades
_____ 3. Learning disability/Attention Deficit Disorder
_____ 4. Unsure of Career Choice
_____ 5. Financial Problems
_____ 6. Too tired to do much of anything
_____ 7. Sleep problems/Nightmares
_____ 8. Headaches
_____ 9. Loss of appetite
_____ 10. Eating habits/problems
_____ 11. Sudden changes in my personality or behavior
_____ 12. Isolating Self
_____ 13. Feel that others do not like me
_____ 14. Uncomfortable at social gatherings
_____ 15. Trust Issues
_____ 16. No close friends
_____ 17. Relationship/Marital problems
_____ 18. Roommate problems
_____ 19. Whether or not to get/stay married
_____ 20. Too easily influenced by other people
_____ 21. Nervous/Worrying too much
_____ 22. Anger
_____ 23. Unhappiness
_____ 24. Feeling guilty
_____ 25. Grief/Loss
_____ 26. Abortion
_____ 27. Dissatisfaction/Loss of interest in things
_____ 28. Lonely
_____ 29. Difficulty expressing my emotions
_____ 30. Feeling Depressed/Sadness
_____ 31. Discouraged about my future
_____ 32. Feeling inferior
_____ 33. Afraid of making mistakes
_____ 34. Failure or rejection
_____ 35. Difficulty making decisions
_____ 36. Unable to concentrate
_____ 37. Sexual Matters
_____ 38. Divorce adjustment
_____ 39. Sexual Assault/Rape
_____ 40. Confused about religious beliefs
_____ 41. Being a nontraditional student
_____ 42. Uncertain about gender identity
_____ 43. Uncertain about sexual identity
_____ 44. Own use of Drugs/Alcohol
_____ 45. Another's use of Drugs/Alcohol
_____ 46. STD/HIV/AIDS
_____ 47. Parental conflict
_____ 48. Family Problems/Pressure
_____ 49. Abuse: emotional ___ sexual ___ physical ___
_____ 50. Thoughts of suicide: within last 24 hours ___ within last week ___ within last 6 months ___
_____ 51. Have you had any serious illness or injuries in your life? If yes, please list: _____ _____
_____ 52. Have you tried to control your weight? If yes, How? Dieting ____ Exercise ____ Vomiting ____ Laxatives ____
_____ 53. Has there been a death of anyone close to you in the last five years? If yes, who? _____
_____ 54. How many times per week do you exercise? One or less ___ Two to four ___ Five or more ___
_____ 55. How many people can you really count on right now, for emotional support? _____

_____ 56. Has any member (s) of your family, other than you: (check all that apply and please specify relationship (s)
_____ been physically/sexually abused by another member _____
_____ been hospitalized for mental disorder _____
_____ had significant problems with alcohol/drugs _____
_____ been imprisoned or trouble with the law _____
_____ been married three or more times _____
_____ had serious medical problems _____

_____ 57. Do you have the desire or need to harm yourself through:
_____ cutting _____ burning _____ severing _____ inserting _____ hitting
_____ constricting _____ picking _____ other _____

Overall, to what extent is your **academic performance** (concentration, memory, motivation, class attendance, assignment completion) being affected by the problem (s) you want to work on in counseling? Please circle a number on the rating scale.

1	2	3	4	5
No Effect	Slight Effect	Moderate Effect	Much Effect	Major Effect

Please state, in your own words, what you would like to discuss with the counselor?

_____
_____
_____
_____
_____
_____

Is there anything else you would like your counselor to know about you?

_____
_____
_____

Please read this list and check the behaviors that you have tried in order to cope with your concerns:

_____ 1. Talked with at least one family member
_____ 2. Talked with at least one friend
_____ 3. Talked with partner/spouse
_____ 4. Talked with minister
_____ 5. Prayer/Meditation
_____ 6. Exercise
_____ 7. Eating
_____ 8. Drugs/Alcohol
_____ 9. Changed physical appearance
_____ 10. Art/Music/Dance
_____ 11. Keeping a journal
_____ 12. Recreational activities/Hobbies
_____ 13. Read self-help books
_____ 14. Worked extra hours/Studied more
_____ 15. Community service
_____ 16. Avoid/Ignore the problems all together

The Counseling Center offers groups each semester which are opportunities to share common concerns with other students. Would you like to be included on a listserv to receive information about groups? _____ Yes _____ No

What are your goals for counseling (i.e., what do you want to occur as a result of counseling)? Please be as specific as possible.

1. _____
2._____
3._____