Patient Paperwork Forms

Forms Include:
Informed Consent
Client Information Form
Consent to Audio and Video
Consent to Treatment for Minors

Please complete the forms below and bring them to your first appointment. You are able to fill in the forms online, but you must print them when you are finished. You will not be able to save the filled-in forms.

This is part of the paperwork that will need to be completed before your first appointment. If you do not wish to complete these forms now, you may complete them at the Counseling Center prior to your first appointment.

You will need to arrive, at least 30 minutes, before your appointment to complete all of your paperwork, unless, you choose to complete the on-line paperwork before your appointment. You will need to arrive at least 5 minutes before your first appointment with your **completed paperwork.**

ALL INFORMATION IS CONFIDENTIAL!

INFORMED CONSENT FOR COUNSELING SERVICES, EXPLANATION OF CONFIDENTIALITY, AND CONSENT FOR DISCLOSURE OF CLINICAL RECORDS AND INFORMATION BAYLOR UNIVERSITY COUNSELING CENTER

COUNSELING SERVICES: Group Services are our recommended treatment at Baylor University Counseling Center (BUCC). We offer group therapy and clinics to address a wide range of concerns that students have. Students participating in the groups and clinics do not have session limits, and they are always free and confidential. If our group services are not appropriate for your concerns, we offer short term counseling in these situations and there may be a waiting period before you start. Students whose concerns indicate a need for long-term services, more intensive services, or specialized services not available at BUCC will be referred to other professionals or agencies in the community. Appointments are scheduled 8 a.m. to 12 noon and 1p.m. to 5 p.m. Monday through Friday. A member of the clinical staff is on call for crisis after regular office hours.

FEES: You have access to BUCC if you have paid the student services fee. (Law and seminary students must have paid the optional student services fee.) The fee schedule is as follows:

Service	Fee
Groups and Clinics	*No charge*
Short-Term Individual Counseling (Initial 7 sessions)	*No charge*
Short-Term Individual Counseling (All additional sessions)	*$10 each*
Short-Term Couples Counseling (Initial 7 sessions)	*No charge*
Short-Term Couples Counseling (All additional sessions)	*$10 each*
Dietitian (First 3 visits)	*No charge*
Dietitian (All additional visits)	*$20 each*
Psychiatric Evaluation	*(Charges billed to Insurance)**
Psychiatric Follow-up	*(Charges billed to Insurance)**

*Psychiatric visits not cancelled at least 3 hours in advance will be charged $10, no-shows for visits will be charged $25.

Charges will be billed to the student through their Baylor University account each month for the previous month's charges. If other arrangements need to be made, please contact the Counseling Center Administrative Assistant.

If, due to an illness or emergency, you are unable to attend your scheduled appointment, please call the Baylor University Counseling Center and cancel the appointment as far in advance as possible.

Initial Here
_______I understand that if I miss my appointment and do not reschedule by 5 p.m. the next business day or if I cancel two consecutive appointments, my appointment time will be assigned to another student. In this event, I understand that counseling services are still available to me, but I will be placed on the waiting list if I want to continue counseling.

TREATMENT PLANNING:

Initial Here
_______Developing a plan for the services I receive with the professional staff at the Baylor University Counseling Center is an important part of my treatment. I understand that I should be, and have the right to be, consulted at the beginning of counseling regarding goals, objectives, and intervention techniques, as well as any time during counseling that these change. To the best of my ability, I will be a full partner in this treatment planning process.

CONFIDENTIALITY AND CONSENT FOR DISCLOSURE OF CLINICAL RECORDS AND INFORMATION

I understand that as part of the provision of health care and counseling services, Baylor University Counseling Center creates and maintains clinical records and other information describing among other things, my medical history, my mental health history, symptoms, assessment and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that I have a right to access and review my clinical record unless deemed harmful to my mental health by my counselor. I understand I can make that request in writing at any time.

I am aware that my appointments, personal demographic data, and clinical records are kept on Center password protected computers and any reports on Center computers are password protected. I am aware this information is maintained in an electronic format that is also used by the Health Center and the following counseling information is available to Health

Center staff: date of last visit, number of visits, counselor name, and diagnoses. Further, I am aware that a file on me is maintained for 10 years or, if I am a minor, for 10 years after I turn 18 years old.

By signing this form, I consent to the use and disclosure of all clinical records maintained by the Baylor University Counseling Center and my protected mental health information for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or in electronic format, are confidential and may only be disclosed for the purposes of treatment, payment or health care operations and as otherwise provided by the Family Educational Rights and Privacy Act (FERPA) and other applicable law.

2. I further consent to release of information from my records in the following circumstances:

    - If referred by someone else, we may confirm attendance at your first session for the referral source. No further information will be provided to them without your written permission.
    - Information released to other professionals involved in treatment. Most commonly this would be to other members of the counseling staff at BUCC (if involved in your treatment), or a Baylor Student Heath Center physician (if assisting in managing your treatment).
    - If you are under 18 years of age, your parents or legal guardian(s) may request access to your records and may authorize their release to other parties.
    - If you are determined to be in imminent danger of harming yourself or someone else.
    - If you disclose sexual misconduct by a therapist.
    - If you disclose abuse or neglect of children, the elderly, or disabled persons.
    - To qualified personnel for certain kinds of program audits or evaluations.
    - To individuals, corporations, or governmental agencies involved in paying or collecting fees for services. This includes insurance companies.

In addition to the gains and positive outcomes that are associated with counseling and therapy, some "side effects" are possible. Because counseling involves discussing issues that have or are presenting you with some difficulty, you may find: 1) the energy it takes to focus on your issue(s) may make it harder to concentrate on other things as much as you'd like; 2) emotions may be more available to you and you may feel moodier; 3) you may see things in new or different ways and this may be confusing or difficult for a short time; and 4) relationships may be affected as you examine interpersonal issues.

COUPLES COUNSELING: Records related to couples counseling sessions are maintained in an individual's record with the identifying information for the spouse or partner removed. Although the information discussed in couples sessions is considered confidential by BUCC staff members, confidentiality by the participating spouse or partner in couples counseling cannot be guaranteed.

GROUP COUNSELING: Records related to group counseling sessions are maintained in a student's individual record with the identifying information for other group members removed. Although the information discussed in group sessions is considered confidential by BUCC staff members, confidentiality by other group members cannot be guaranteed. Confidentiality will be discussed and strongly encouraged among all group members as a vital part of group membership.

NOTE: Students should be aware that many states, including Texas, ask about therapy as part of application to the bar. In a few states 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 for sensitive government positions. In the past we have responded to these requests with brief summaries, which have been sufficient. This information is only released with your written consent.

I UNDERSTAND THE LIMITS TO CONFIDENTIALITY STATED ABOVE AND ACCEPT THEM AS PART OF THE CONDITIONS OF RECEIVING SERVICES AT THE BAYLOR UNIVERSITY COUNSELING CENTER. I FURTHER CONSENT TO THE DISCLOSURE OF MY COUNSELING CENTER RECORDS AS EXPLAINED IN THIS CONSENT. I understand that I may withdraw this consent in writing and terminate treatment at any time.

____________________________ ____________________________

Client's Name *(please print)* Client's Signature

____

Date

If you have any questions about this form, please ask your counselor.

BAYLOR UNIVERSITY COUNSELING CENTER (BUCC)
Client Information Form

DIRECTIONS: Please complete the following form and bring with you to your first appointment. If you do not complete this form prior to your initial appointment, ***your appointment may need to be rescheduled***. If you choose to complete it at the Counseling Center prior to your first appointment, please plan to come to your appointment ***at least one-half hour before your scheduled time.*** Completion of this form is not mandatory in order to be seen at the Counseling Center, but doing so will enable us to provide you with more comprehensive and timely service. ***ALL INFORMATION IS CONFIDENTIAL!***

Date: ________________ID#:___________________Referred by:_________________________
Name: _____________________________________Date of Birth:___________Age:_________
Mailing Address: ____

____
City State Zip

Phone: (Cell) ________________ (May we call or leave a message at this number?) Y___N___
(Home) ________________ (May we call or leave a message at this number?) Y___N___
E-mail Address: ___________________________________ (May we e-mail you?) Y___N___
(Note: Because e-mail is not confidential, we strongly discourage you from using e-mail to communicate sensitive information with your counselor.)

Roommates(s): (1)______________________________(2)_______________________________
(3)______________________________(4)_______________________________
Employment: ____Hrs. per week:___________

Do you have health insurance? Y__N__If so, what company? ____________________________
Policy Group # ________________________ Member/Subscriber # ______________________
NOTE: Baylor University Counseling Center DOES NOT file insurance for you. However, we can provide receipts for you to file with your insurance company.

FAMILY INFORMATION:

	NAME	AGE	LEVEL OF EDUCATION	OCCUPATION
Father	___________________	_____	______________________	________________
Mother	___________________	_____	______________________	________________
Siblings	___________________	_____	______________________	________________
	___________________	_____	______________________	________________
	___________________	_____	______________________	________________
	___________________	_____	______________________	________________

Parent's Address: ________________________City: _______________State: ____Zip: _______
________________________City: _______________State: ____Zip: _______
Parent's Phone Number:(H)_________________(W)________________(CP)________________
(H)_________________(W)________________(CP)________________

ACADEMIC INFORMATION:
Classification: ______________________Hours attempted this semester: ________Overall GPA:______ Expected Date of Graduation: ________________ Major: _____________________
Probable Occupation: ____

GENERAL INFORMATION:
Have you received services from the Baylor Counseling Center before? Y___N___
If yes, please check all that are applicable:
___Counseling: Dates: ______________________________________
___Psychiatric: Dates: ______________________________________

___Nutritional: Dates: ____________________________________

Have you previously received psychological/psychiatric services elsewhere? Y___N___
If yes, date(s) and type of service: ____
Have you ever been hospitalized for psychological/psychiatric care? Y___ N___
If yes, date(s) and reason: ____
Do you have any medical problems for which you are currently being treated? Y___N___
If yes, please explain: ____
Are you taking any medication(s)? Y___N___
If yes, please list: ____
Have you ever been arrested for or convicted of a crime? Y___N___
If yes, date(s) and reason for arrest(s) or conviction(s):
____

FAMILY HISTORY: (Check any that are/were present in your family.)
Who in your family has experienced:
___Depression ____
___Anxiety ____
___Substance Abuse ____
___Suicide Attempt ____
___Physical Abuse ____
___Sexual Abuse ____
___Eating Disorder ____
___Other Psychiatric/Emotional Disturbance (explain) ______________________
____
___None

Briefly describe the primary reason(s) you are seeking counseling and/or consultation:
____
____

BUCC SERVICES:
At Baylor University Counseling Center group services are our recommended treatment. Please indicate the groups you might be interested in for your treatment by marking a 1, 2 or 3 below, in order of preference (see Group Handout for details on each group).

Creative Arts Group___
Family Exploration Group___
Mindfulness Group___
Eating Recovery Group___
Men's Issues Group___
Women's Issues Group___
The Survivor's Group___
Addiction & Recovery Process Group___
Social Confidence Group___

We also offer the following clinics (see Group Handout for details). Please check below if you are interested in one of the clinics.

M&M Clinic___ Coping Clinic___ Mood Management Clinic___
At Baylor University Counseling Center we also offer psycho-educational materials and consultation services. When appropriate, we offer short-term counseling based on availability of counselors. If your concerns are outside our short-term scope of service, or require a specialization we do not offer, we can provide an assisted referral process to help you find the right resource. **Please check the services you are interested in discussing with the triage counselor at your first appointment.**

___Self-help materials
___Brief problem-solving (1-2 sessions)
___Short-Term Individual counseling, short (1-4 sessions)
___Short-Term Individual counseling (4-12 sessions)
___Long-term individual counseling
___Group counseling
___Referral to other appropriate services
___Psychiatric assessment and services
___Dietitian assessment and services

How are your concerns affecting you ACADEMICALLY? Check all that apply.
___Concentration ___Academic Probation ___Performance ___Failing Exam(s) ___ Grades
___Missing assignment(s) ___Absenteeism ___Other ___________________________________
___None of the above

How are your concerns affecting you in other areas of your life? (i.e. socially, relationship, family, work, etc.)
____
____
____

What are your goals for counseling?____
____

In what ways do you expect counseling to help you?_____________________________________
____
____

Who are the people in your life you will turn to for support while making changes in your life?
____
____

Please check any of the following concerns you are currently experiencing or have experienced:

Present	Past	
_____	_____	Anxiety
_____	_____	Depression
_____	_____	Bipolar disorder
_____	_____	Unwanted sexual experience
_____	_____	Sleep disturbance
_____	_____	Changes in appetite
_____	_____	Academic problem
_____	_____	Relationship concerns (e.g. break up, conflict)
_____	_____	Relationship violence (e.g. emotional, physical, sexual, verbal abuse)
_____	_____	Panic attacks
_____	_____	Shyness or Social Anxiety
_____	_____	Test Anxiety
_____	_____	Obsessive compulsive behavior
_____	_____	Phobia
_____	_____	Stress
_____	_____	Thoughts of suicide
_____	_____	Suicide attempt(s)
_____	_____	Self-Injury (e.g. cutting, burning, banging head, etc.)
_____	_____	Difficulty concentrating
_____	_____	ADHD
_____	_____	Low motivation or energy
_____	_____	Severe mood swings
_____	_____	Loneliness
_____	_____	Anorexia
_____	_____	Bulimia
_____	_____	Disordered eating
_____	_____	Anger management
_____	_____	Family concerns
_____	_____	Traumatic event
_____	_____	Physical abuse
_____	_____	Sexual abuse
_____	_____	Pornography use

_____ _____ Gambling
_____ _____ Recent death or loss
_____ _____ Legal/Judicial Affairs problem
_____ _____ Alcohol abuse
_____ _____ Marijuana use
_____ _____ Other drugs (e.g. methamphetamine, cocaine, etc.)
_____ _____ Sexual dysfunction
_____ _____ Health concern
_____ _____ Work-related concern
_____ _____ Identity problem
_____ _____ Religious or spiritual problem
_____ _____ Cultural concerns
_____ _____ Excessive video or online game use
_____ _____ Other: ______________________________

What do you see as your top 5 **strengths**?
1. ____________________ 2. ____________________ 3. ____________________
4. ____________________ 5. ____________________

What do you do for self-care (i.e. hobbies, interests, etc.)?
____

Please check the times when you are AVAILABLE for counseling.					
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
8 AM					
9 AM					
10 AM					
11 AM					
1 PM					
2 PM					
3 PM					
4 PM					

THANK YOU!! You and your triage counselor will determine the most appropriate therapeutic service for your particular concern. Options include:
Groups & Clinics, Short-Term Individual Counseling, Short-Term Couple's Counseling, Psychiatric Services, Dietitian Services and Referral to the Community.

CONSENT FOR VIDEO/AUDIO TAPING

BAYLOR UNIVERSITY COUNSELING CENTER
One Bear Place # 97060
Waco, TX 76798-7060

I, the undersigned student, consent to have my individual/group counseling sessions video/audio taped by staff psychologists and/or graduate assistant counselors for the purpose of supervision and training. I understand that counseling services provided by the graduate assistant counselors is supervised on an ongoing basis. I am also aware that this consent may be revoked at any time while I am receiving counseling services. I further understand that the content of the video/audio tapes is confidential and will only be used for supervision/training of Counseling Services staff members. All video/audio tapes will be erased upon my request or when I am no longer receiving counseling services.

I warrant that I am over eighteen (18) years of age and have full authority to execute this instrument and that this instrument is executed by me voluntarily and of my own free will.

If you have questions about this form please speak with your counselor.

______________________	____
Date	***Client***

This consent will be null and void as of June 30, 20___,

This consent may be revoked at any time by the person giving authorization by signing and dating the revocation statement below.

I hereby withdraw my consent to be video/audio taped and request that all tapes made prior to the date below be erased.

______________________	____
Date	***Client***
______________________	____
Date	***Representative of Counseling Services***

Consent to Treatment for Minors

(Please complete and discuss with your counselor if you are 17 years of age or under)

I, _____________________________, verify that I am 16 or 17 years of age, live apart from my parents or guardians, and manage my own financial affairs, and hereby consent to treatment at the Baylor University Counseling Center.

I understand that although I am able to consent to treatment, my parents or guardians may request access to information in my records.

I also understand that with or without my consent, the mental health professional providing treatment at the Baylor University Counseling Center may release information to my parents or guardians regarding treatment being provided or needed under the following circumstances: sexual, physical, or emotional abuse, contemplating suicide, or suffering from a chemical or drug addiction or dependency. The decision to release information to your parents or guardians under these circumstances will be made if it is determined to be in your interest. A reasonable effort will be made to discuss this decision with you prior to releasing information.

I have been informed of my right to consent to treatment and the potential limits to my confidentiality.

____ _______________________

Signature Date