OHIO UNIVERSITY
Division of Student Affairs

Counseling and Psychological Services
Hudson Health Center 3rd Floor
1 Ohio University Drive
Athens, OH 45701-2979

T: 740-593-1616
F: 740-593-0091
www.ohio.edu/counseling

Office Use Only
Arrival:
Completed:

NON-STUDENT PARTNERS IN COUPLES COUNSELING—CONSENT FOR TREATMENT

NAME:FIRST____________________________**M.I.**____**LAST**__________________________________**Date of Birth:**____________________

Today you will be meeting with a clinician at CPS who will:

- explore your concerns and help identify your needs
- make recommendations about other services, resources and activities (for example, exercise, other self-care techniques, evaluation for medication, stress clinic, group counseling, individual therapy)
- provide you with information about your options for counseling services (for example, Counseling and Psychological Services, private practitioners, other community mental health agencies, and/or other campus departments).

You will be talking with a licensed mental health professional (e.g. psychologist) or a psychology/counseling trainee who is supervised according to Ohio law. Supervisors will have knowledge of your counseling sessions and access to your counseling file. You have the right to ask for an appointment with your counselor's supervisor at any time. You may be asked to sign a Supervision Disclosure Form that identifies the name of your counselor's supervisor.

NATURE AND SCOPE OF OUR CENTER'S SERVICES

Counseling Services offered in our center include crisis intervention, individual, couples and group counseling. Couples counseling sessions end 45-50 minutes after the scheduled start time. We operate from a short-term treatment model. If long-term couples counseling services are requested, outside referrals or other services will be recommended. In the event that you should ever be unable to keep a scheduled counseling appointment, **please give our staff 24-hour notice**. Failure to keep appointments may delay future services.

AS A NON-OHIO UNIVERSITY STUDENT, YOU ARE ONLY ELIGIBLE FOR COUPLES COUNSELING AND ONLY FOR AS LONG AS YOUR PARTNER IS A OHIO UNIVERSITY STUDENT AND IS PARTICIPATING IN COUPLES COUNSELING.

OUR ASSIGNMENT PROCESS AND EMERGENCY CONTACT INFORMATION

If your appointment today results in a recommendation for ongoing couples counseling services at CPS, the staff member who is assigned as your clinician may not be the same person you meet with in today's session. Every effort is made to connect you and your partner with a clinician as soon as possible.

CONFIDENTIALITY

Information that you reveal, whether oral or written, will not be discussed with anyone outside the CPS's professional staff without your written permission. However, some circumstances constitute exceptions to confidentiality and may result in release of limited information to appropriate individuals. These circumstances include: potential harm to self or others (e.g. suicide, homicide, or other life threatening behaviors), suspected child or elder abuse or neglect, and instances in which a court may subpoena counseling records (e.g., contested divorce actions, PATRIOT Act.) If you have any concerns about our procedures, records, supervision, confidentiality, or professional qualifications, please make them known to your clinician at any time.

Information from your records might be included in service evaluation or descriptive research. If so, at no time will your identity be disclosed nor will the information be associated with you individually (i.e., information from your records would only be included in the tabulation of group scores, ratings, etc.).

RECORDING OF SESSIONS

Audio/Video (A/V) recording helps CPS staff provide superior quality services to you. You are encouraged but not required to allow recording of your sessions. A/V recording is often required when the clinician is working under a supervisor's license. These A/V recordings are only reviewed by clinical staff and their supervisees, as required by law and to ensure best practices. Each recording is deleted after appropriate review. Your signature below grants permission to A/V record your sessions.

____
Client Signature Date

I AM REQUESTING SERVICES FOR MYSELF AND CONSENT TO PARTICIPATE IN COUNSELING I understand that my participation at Counseling and Psychological Services is strictly voluntary. I have asked for any needed clarification of the conditions mentioned above, I am satisfied with the explanations and I agree to abide by these conditions. I consent to participate in services provided at CPS and I understand that I may withdraw consent at any time.

____
Client Signature Date

____
Witness Signature Date

CLIENT SCHEDULE

FALL/SPRING/SUMMER (CIRCLE) __________________________ YEAR

Please put an X through the times that you are **NOT AVAILABLE**.

	Monday	Tuesday	Wednesday	Thursday	Friday
8					
8:30					
9					
9:30					
10					
10:30					
11					
11:30					
12noon					
12:30					
1					
1:30					
2					
2:30					
3					
3:30					
4					
4:30					