UNIVERSITY OF SOUTH CAROLINA SCHOOL OF MEDICINE COLUMBIA
STUDENT COUNSELING SERVICES

CONSENT TO COUNSELING TREATMENT

You have the right to know about the services that you receive. We will try to give you as much information as we can about what to expect before we begin counseling. Please review the following information. If you have any questions, ask your Counselor. We want you to understand your rights before you agree to counseling treatment.

General Practices

The Student Counseling Services provided through the University of South Carolina School of Medicine Columbia will be provided by licensed counselors and psychologists.

The types of counseling treatments and what we do to help will depend on the needs of the Student. Your Counselor will explain what will happen during your session.

Confidentiality

Your Counselor will abide by the state law on confidentiality. What you say and the records we keep will be kept private. They can only be released with your written approval. However, there are times when we may be compelled to release information about students:

1) When a student is a danger to him or herself, or dangerous to others, we may have to inform family members and/or the proper authorities.
2) We are mandated to report known or suspected child or vulnerable adult abuse to the proper authorities.
3) In some cases, a judge has the legal authority, regardless of your wishes, to require us to release information and/or testify in court. Aside from this, the counselors do not testify in court.

If you are unhappy with our services, please tell us. If we are not providing the services you need, we can help you find other services that are better for you.

By signing this consent, I acknowledge that I have discussed my treatment with my Counselor. I fully understand my privileges and I agree with the treatment being offered to me. Also, when group therapy services are received, I agree to respect the confidentiality of other group members; by not discussing group or revealing names to others outside group therapy.

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CONSENT FOR TELEHEALTH SERVICES

In some situations, it may be agreed between Student and the Counselor that telehealth services are more feasible. Please read the following as this is an agreement between you and the University of South Carolina School of Medicine Student Counseling Services for telehealth services.

- There are some benefits of telehealth sessions. For example, you can continue services when restricted to your home, but there are also some risks. For example, depending on where you are, your sessions may be less private than when we meet in person.
- We will have the same limits of confidentiality that we discussed in the Consent to Counseling Treatment section. For example, if we believe you are a danger to yourself or others, we may have to get others involved.
- For each session, we need your physical address and a safety plan that includes at least one emergency contact.
- If it is decided that telehealth sessions are no longer appropriate for you, we may resume in-person sessions, if possible, or will help you find other resources.
- It is important to be on time for our sessions. If you need to cancel or change your appointment time, please let your Counselor know in advance by phone or email.
- It is important to be in a quiet, private space that is free of distractions (including cell phones or other devices) during the session. Consider using earbuds or headphones so that others cannot overhear conversations.
- We need a back-up plan (e.g., phone number where you can be reached0 to conclude, restart, or reschedule a session in the event of technical problems.

STUDENT CONSENT AND UNDERSTANDING

I understand all the information provided above in both the Consent for Counseling Treatment and/or the Consent for Telehealth Services. I understand there are risks associated with the videoconferencing technology. I agree to these terms and consent to telehealth services for my counseling. I understand that I can withdraw my consent for either or both services at any time by notifying my counselor verbally or in writing.

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Consent for Counseling Treatment

Student Name (please print)	Signature	Date
Counselor Name (please print)	Signature	Date

Consent for Telehealth Services

Student Name (please print)	Signature	Date
Counselor Name (please print)	Signature	Date

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STUDENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgement)

I, _____, have received a copy of the

Notice of Privacy Practices from (Counselor.Name) _____.

_____

Student Name (Print)

_____

Student Signature

_____

Date

For Office Use Only

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Consent to Communicate with Others about my Counseling Treatment

☐ I would like to designate a family member or other individual(s) with whom the University of South Carolina School of Medicine Counseling, Columbia, may discuss my medical records as specified below. ***The information to be disclosed is marked by an [X] in the boxes***¡

1. Name ____ Relationship to student ____ Phone #

☐ Name of counselor	☐ Assessment Report	☐ Treatment compliance
☐ Attendance	☐ Treatment Plan	☐ Current medications
☐ Scheduled appointments	☐ Progress Notes	☐ Other: _____

2. Name ____ Relationship to student ____ Phone #

☐ Name of counselor	☐ Assessment Report	☐ Treatment compliance
☐ Attendance	☐ Treatment Plan	☐ Current medications
☐ Scheduled appointments	☐ Progress Notes	☐ Other: _____

3. Name ____ Relationship to student ____ Phone #

☐ Name of counselor	☐ Assessment Report	☐ Treatment compliance
☐ Attendance	☐ Treatment Plan	☐ Current medications
☐ Scheduled appointments	☐ Progress Notes	☐ Other: _____

Student Name (please print)	Signature	Date
Counselor Name (please print)	Signature	Date

REVOCATION OF CONSENT

If, at any time, I wish to revoke this consent, I may do so by requesting this document from my file and signing below. Sign the line below only if you wish to revoke and/or revise the original consent to communicate with others.

Student Name please	Signature	Date
Student Name (please print)	Signature	Date

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Consent for Electronic-Based Communication

COMMUNICATION WITH COUNSELOR:

In order for your Counselor to communicate with a Student using email, electronic attachments, and/or texts or phone calls (i.e., using internet phone systems such as Google Voice™), we need to make sure the Student is aware of confidentiality and other issues that arise when we communicate this way and to document that the Student is aware of these and agrees to them. As the Student, I understand that:

- All email messages and internet phone communication, sent over the Internet are not encrypted or secure, and may be read or viewed by others.
- Email cannot be used for the provision of therapy.
- All email is backed up on the University of South Carolina School of Medicine Columbia's server. The University of South Carolina School of Medicine Columbia administration reserves the right to monitor email usage and might, therefore, see the text of any message.
- When the Counselor responds to email, he/she will respond to the address from which it is sent.
- While Counselors attempt to check their email on a regular basis, they cannot guarantee that any email message will be read and responded to within any particular time frame. In the case of an emergency, the Student should call 911.

By signing this consent, I (the Student) acknowledge that my Counselor has discussed the guidelines and risks of using email, electronic attachments, and text messages. I have informed my Counselor of any specific type of communication that I do not want sent by email. I understand the risks of online communication and authorize the use of:

☐ I do NOT wish to utilize electronic-based communication with my Counselor.

☐ I wish to utilize the following electronic-based forms of communication with my counselor.

Texts and phone calls with counselor using Google Voice internet phone system.

Email without attachments.

Email attachments with protected health information (PHI)

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APPOINTMENT REMINDERS:

Students counseled through the University of South Carolina School of Medicine Columbia also can receive a reminder for an upcoming appointment via email and/or text message. Please complete this form and sign below to give your permission to provide an automatic appointment reminder service.

Email Address: _____

Cell Phone # _____

By signing this consent, I (the Student) acknowledge that this request will apply to all future appointment reminders unless I request a change in writing.

Student Name (please print)	Signature	Date

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Description of Services

Welcome to University of South Carolina School of Medicine Columbia Counseling Services.

All services are provided by licensed clinical social workers or counselors. The first few sessions will be dedicated to assessment and evaluation to determine the student's specific counseling needs. The goal of these evaluative sessions will be to develop a treatment plan together. If it is determined that the University of South Carolina School of Medicine Columbia Counseling is not capable of meeting the student's specific needs, s/he will be referred to an appropriate counselor or provider.

Students should be aware that counseling services involve a joint effort between counselor and student, the results of which cannot be guaranteed. For example, progress in therapy depends on many factors including motivation, effort, and other life circumstances such as the student's interactions with family, friends, and other associations.

Emergency Procedures

Counseling services are not always available. When not open, students in crisis are advised to seek emergency services through one or more of the following service agencies or call 911.

Palmetto Health Richland
5 Medical Park Rd, Columbia, SC 29203
803-434-7000 or Behavioral Care: 803-434-4800

National Suicide & Crisis Lifeline
988

Three Rivers
2900 Sunset Blvd, West Columbia
803-796-9911

Columbia Area Mental Health
2715 Colonial Drive, Bldg. 200-B, Columbia
803-898-8888