Hale Malama Care Center
Library Resource Center (LRC) Room 120
3-1901 Kaumuali'i Highway
Lihue, Hawaii 96766
Phone: 808-245-8314
Email: kohatsub@hawaii.edu

UNIVERSITY of HAWAI'I®
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INFORMED CONSENT FOR COUNSELING SERVICES

Eligibility, Appropriateness, and Referrals
Eligibility for personal counseling and case management with the Hale Malama Care Center is based upon student's status as an enrolled Kauai Community College (KCC) student. A prospective or disqualified student may be eligible for educational counseling sessions.

Your First Appointment
During your first visit, you will spend time with a counselor discussing your immediate concerns. This will help both you and your counselor decide how the Hale Malama Care Center can best help you. These services may consist of individual counseling, group counseling, psycho-educational classes, and/or an appointment with a consulting provider. In some instances, you may be referred to an off-campus service for longer-term, intensive therapy or some other mental health expertise not offered through the Hale Malama Care Center.

Additional Appointments
Counseling sessions are scheduled for a maximum of 45 minutes. During an early visit with your counselor you both will decide the goals of your work and the approximate length of the counseling contract. Because of the large number of students requesting counseling, the Counseling Service generally provides short-term therapy.

Program Fees
There is no fee for our counseling services. If our services do not meet your needs, you will be referred to an off-campus professional. You are responsible for that professional's office fees.

Risks and Benefits
There are risks and benefits associated with counseling. Benefits of counseling typically include symptom relief, an enhanced sense of well-being, an increased ability to cope with peer and family relationships and academic pressures. You may also gain a better understanding of yourself which will assist in your personal development. On the other hand, counseling often involves discussing unpleasant aspects of life, thus people in counseling may experience unpleasant emotions like sadness, guilt, anger, frustration, and loneliness. It is important for you to discuss with your counselor any questions or discomfort you have regarding the counseling process. Finally, people benefit from counseling in different degrees. It is normal that some people find some types of counseling not helpful. You are encouraged to talk to your counselor to find out what may work for you.

Confidentiality
Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

What we discuss in our sessions will remain confidential per FERPA regulations. We may consult and exchange information with others on our Hale Malama care team to support your success and campus' safety. No information will be released to a third party outside of Hale Malama Care Center without your written consent unless mandated by law. There are possible exceptions to confidentiality and are explained in the Notice of Privacy Practices.

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Duty to Warn
In the event that the counselor reasonably believes that the student is a danger, physically or emotionally, to themselves or another person, your consent is given for the counselor to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of services.

Cancellations and Not Showing-Up for an Appointment
A personal commitment is crucial to the success of counseling. Please keep all of your scheduled appointments. If you need to cancel, do so as far in advance as possible. A series of missed appointments may necessitate a referral to an off-campus provider.

Mutual Respect
Counseling is based on an underlying principle of deep respect for each student who comes for help. The Hale Malama Care Center is committed to this principle and expects you in turn to behave in a respectful manner with program counselors and employees. Verbal abuse may trigger termination of services with a referral to the Dean of Students for follow-up. No form of physical violence will be tolerated. Sexual relations between client and his/her therapist is against the law. Racism, sexism and other forms of discrimination are not permitted. Being under the influence of any mind-altering substance is prohibited.

Professional Records
The laws and standards of mental health treatment require that records be kept. Our program follows all state and federal laws and professional standards. All records, either written and/or electronic form will be kept strictly confidential per these laws and by professional ethical standards. I understand that Hale Malama Care Center treatment records are separate from my educational records per state and federal laws. The process to access your records are detailed in the Notice of Privacy Practices.

Contacting Our Office
Hale Malama Care Center counselors are often not immediately available by telephone. We do not answer our phones when with clients and may be otherwise unavailable. At these times, you may leave a message on the confidential voice mail and your call will be returned as soon as possible. It may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) Call the ACCESS Line at (808) 832-3100 or the Crisis Text Line at 741741. If it is an emergency, call 911 or go to the nearest emergency room.

Electronic Mail Communications
The confidentiality of electronic mail (e-mail) transmission cannot be guaranteed. For this reason, the Hale Malama Care Center discourages the sharing of compromising personal or clinical information through this medium. In addition, students should be aware that our counselors may not always have immediate access to their email.

Social Networking Policy
Hale Malama Care Center counselors will not accept "friend or contact requests" from current or former client's social networking site (e.g., Facebook, LinkedIn, etc.). Adding current or former counselors as friends or contacts on social networking sites can compromise confidentiality and privacy for both the student and the counselor.

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Additional Rights

If you are unhappy with what is happening in therapy, we hope you will talk with your counselor so that he/she/they can respond to your concerns. Such comments will be taken seriously and handled with care and respect.

You may also request a referral to another therapist and are free to end therapy at any time.

You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.

You have the right to ask questions about any aspects of therapy and about my specific training and experience.

You have the right to expect that your counselor will not have social or sexual relationships with clients or with former clients.

You have the right to file a complaint. If you believe your privacy has been violated, you may file a complaint with the Vice Chancellor of Student Affairs office in writing.

If there are any concerns with Hale Malama Care Center, please contact the Vice Chancellor of Student Affairs, Margaret Sanchez at (808) 245-8274 or masanche@hawaii.edu

CONSENT TO SERVICES

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices, have had the chance to discuss any questions regarding the above and that you understand and agree to the terms described here.

Student Signature: ____ *Date:* ____________________

Counselor Signature: ____ *Date:* ____________________

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STUDENT INFORMATION

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Who referred you?

□ Self □ Instructor □ Academic Advisor □ Faculty/Staff □ Friend □ Other: ________________

Reason for referral ____

Today's Date: (MM/DD/YYYY) ____/____/____ **UH Student ID:**___________

Last Name: ________________________ **First Name:** ________________________________ **M.I.:** _____

Preferred Name: ___________________________ **Date of Birth** (MM/DD/YYYY): ____/_____/_____

Gender: □ Male □ Female □ Non-binary □ Prefer not to self-describe □ Prefer not to say

Home Phone: ( ) ________-__________ Is it ok to call and leave a message? □ Yes □ No

Cell Phone: ( ) ________-___________ Is it ok to call and leave a message? □ Yes □ No

Is it ok to TEXT to your mobile phone? □ Yes □ No

UH Email: ___________________________@hawaii.edu

*Please note that email is not considered confidential communication

LOCAL ADDRESS

____
____
____

MAILING ADDRESS (if different from above)

____
____
____

EMERGENCY CONTACT

1. Name: _____________________________ Phone: ( ) _________-__________

Relationship: _________________________ Alt. Phone: ( ) _________-_________

LIVING INFORMATION

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Relationship Status: □ Single □ Married □ Partnered □ Divorced/Separated □ Widow □ Other__________
Who currently lives with you?____
How long have you lived at your current local address? (mo/yr) ______________________________
How long have you been on Kauaʻi, HI?______________________________________

Where were you born? And raised?____
How many siblings do you have?____
Names and ages of your children:____
Names and ages of your step children:______________________________________

RACE/ETHNICITY

□ Native Hawaiian □ Native American □ White/Caucasian □ Asian □ African American
□ Hispanic/Latino □ Pacific Islander □ Multi-ethnic__________________ □ Other: ____________________

SEXUAL ORIENTATION

□ Straight □ Lesbian □ Gay □ Bisexual □ Uncertain/Questioning □ Prefer not to answer

RELIGIOUS/SPIRITUAL PREFERENCE

What is your religious or spiritual preference? _______________________________________

ACADEMIC INFORMATION

Major (if declared): ____________________________ Status: □Full Time □Part Time
Involvement with Student Organizations: □Yes □No
*If yes, please list: ____

EMPLOYMENT □ Full-Time □ Part-Time □ Self-Employed □ Unemployed
Employer:____ Since when?______________________
What type of work do you do?____

MILITARY □ Not Applicable

Status: □ Active □ Inactive □ Veteran □ Dependent □ Disabled
Branch: □ Air Force □ Coast Guard □ Army □ Navy □ Marines □ National Guard

If you served in a NON-US armed forces, which one and when ______________________________

Has your military career included any exposure to any traumatic or highly stressful experiences that continue to bother you? □ Yes □ No

DISABILITY

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Are you registered with the Disabled Student Support Office at Hale Malama, as having a documented and diagnosed disability? □ Yes □ No
If yes, please indicate which category of disability services you are registered for (check all that apply):
□ Deaf or Hard of hearing □ Learning Disorders □ Attention Deficit/Hyperactivity Disorders

□ Mobility Impairments □ Neurological Disorders □ Physical/Health Related Disorders □ Visual Impairments
□ Psychological Disorders □ Other: ___________________________________

HEALTH INSURANCE

Do you have health insurance? □ Yes □ No

Who is your health insurance provider? ____

*insurance is NOT necessary for services through our Hale Malama Care Center.

HEALTH

Are you currently (or within the past year) under the care of a medical doctor? □ Yes □ No
If yes, for what condition? ____

Do you have any other significant medical condition? □ Yes □ No

List any physical illness or symptoms the client is having at this time: _____________________________
____

List major surgeries or illnesses in the last five years: ____
____

List current medications: ____
____

Physician prescribing medications for mental health issues: ____________________________________

Have you been hospitalized for mental health concerns? □ Yes □ No
If yes, where? ________________________________ When? ___________________________________

Are you presently receiving counseling/psychiatric services from another provider or agency? □Yes □No
If yes, where? __________________________________ Name of provider? _____________________________

Overall, do you consider yourself a healthy person? □Yes □No

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PREVIOUS BEHAVIORAL HEALTH SERVICES

Has the client ever received help for mental health issues? □Yes □No If yes, when and where?
____

Has the client ever been hospitalized for mental health issues? □Yes □No
If yes, when and where?____

Have the client or anyone in the client's family experienced domestic violence or abuse? □Yes □No

Is the client currently experiencing domestic violence or abuse? □Yes □No

ALCOHOL & DRUG USE

Have you ever received treatment for alcohol and/or drug use? □Yes □No
If yes, when and where?____

Over the last two weeks, how many times have you had five (5) or more drinks* in a row?
*drink is defined as a bottle/can of beer, glass of wine, wine cooler, a mixed drink, or a shot of liquor)
□ None □ Once □ Twice □ 3 to 5 times □ 6 to 9 times □ 10 or more times

Over the last two weeks, how many times have you smoked marijuana?
□ None □ Once □ Twice □ 3 to 5 times □ 6 to 9 times □ 10 or more times

Please check any drugs you have ever used:
□ None □ Cocaine/Crack □ Ecstasy □ Spice □ Bath Salts □ Methamphetamine □ Inhalants
□ Prescription drugs □ LSD □ PCP □ Other

Are any of the following conditions a problem for you at this time? (Check the ones that apply)

☐ Thoughts of suicide
☐ Plans to harm self
☐ Thoughts of harming someone else
☐ Plans to harm someone else
☐ Self-injury
☐ Depression
☐ Grief
☐ Stress
☐ Loneliness
☐ Guilt feelings
☐ Loss of hope
☐ Loss of meaning in life
☐ Problems with sleep
☐ Anxiety
☐ Panic Attacks
☐ Chronic fear
☐ Irrational fears
☐ Problems due to abuse or trauma
☐ Obsessions/compulsions
☐ Behavioral problems
☐ ADHD
☐ Anger
☐ Rage
☐ Problems with relationship partner
☐ Sexual problems
☐ Sexual orientation
☐ Gender identity issues
☐ Relationship to parents
☐ Relationship to children
☐ Conflicts at work
☐ Problems in school
☐ Loss of faith in God
☐ Religious doubts

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☐ Substance abuse ☐ Other? Explain:

Please briefly describe you reasons for seeking mental health & wellness support today:

____

____

____

____

Mahalo for taking the time to complete this form. Please review it to be sure you have completed all sections. Upon completion, if you are satisfied with your answers, please sign and date.

_______________________________________ ____________________________

Name Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My Treatment Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to the Department of Social Services.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by law to immediately make a report and provide relevant information to the Department of Welfare or Social Services.

· Health Oversight: State law requires that licensed mental health professionals (psychologists, licensed clinical social workers, licensed mental health counselors] report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will

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not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of

Court. In civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Hawaii has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

· Serious Threat to Health or Safety: Under state law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

· Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission. [This sentence is now required under the HIPAA "Final Rule."]

III. Patient's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

. · Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of

copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me.

In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to the Vice Chancellor of Student Affairs office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: _________________

I have the right to file a complaint. If I believe my privacy has been violated, I may file a complaint with the Vice Chancellor of Student Affairs office in writing.

If there are any concerns with Hale Malama Care Center, please contact the Vice Chancellor of Student Affairs, Margaret Sanchez at (808) 245-8274 or masanche@hawaii.edu

I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of Kaua'i Community College, Hale Malama Care Center for counseling services. I hereby give my consent to authorize Kaua'i Community College, Hale Malama Care Center counselor to evaluate, counsel, and/or refer me to others as needed.

I have had the opportunity to discuss any questions regarding the above information.

Student Signature: ____ *Date:* ____________________

Counselor Signature: ____ *Date:* ____________________

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ADDENDUM
CONSENT TO SERVICES
DISTANCE COUNSELING or TELEMENTAL HEALTH (TMH) SERVICES

Eligibility
Services of the Hale Malama Care Center are for students enrolled at Kaua'i Community College.

Eligibility and acceptance for TMH services will be based is appropriateness. TMH services are most suitable for clients over the age of 18 years-old who have either previously engaged in formal counseling services and/or are seeking short-term support for issues that are unrelated to major crisis, severe mental health issues, suicidal, homicidal or violent behavior (past and present). If it is determined that TMH is not in your best interest alternative therapeutic interventions will be recommended.

TMH services are *not intended* for students who have a history of major psychiatric episodes, hospitalizations or drug/alcohol dependence; have been diagnosed as any of the following - Borderline Personality Disorder, Major Depressive Disorder, Bipolar Disorder Type 1, Mentally Ill/Chemically Addicted (MICA), and/or Schizophrenia or; have a history of suicidal, homicidal or violent behavior or present as suicidal, homicidal or violent.

If you are considering suicide, or believe yourself to be a potential safety threat to others, call 911, the State ACCESS Crisis Line (808) 832-3100, or seek emergency care at a local hospital.

Full Mental Health Disclosure & Provider's Right To Refuse
If you have any history of major psychiatric episodes, hospitalizations or drug/alcohol dependence or have been diagnosed as any of the following - Borderline Personality Disorder, Major Depressive Disorder, Bipolar Disorder Type 1, Mentally Ill/Chemically Addicted (MICA), and/or Schizophrenia.

YOU MUST *disclose this information to your counselor prior to being considered for TMH services*.

Failure to do so or knowingly misleading or withholding the above said information excludes Hale Malama Care Center's mental health counselors from any legal obligation or liability related to your diagnosis, prognosis, outcome and actions.

If it is deemed at any point in the treatment that your needs are greater than your counselor's area of expertise or scope of practice and you are unsuitable for TMH services, your counselor reserves the right to refuse and/or end treatment and provide appropriate referral sources.

Nature of Tele Mental Health (TMH) Services

Telehealth is a broad term that refers to health services and information provided electronically and has been defined as the practice of mental health specialties at a distance. TMH is also known as distance counseling, E-therapy, teletherapies, cybertherapy, telepsychiatry, telepsychology, telemental health, and telebehavioral health. TMH may be facilitated via video conferencing, email, text messages, chat tools, and/or telephone. TMH is subject to all practice and ethical considerations discussed in this document and stated by the laws, rules and regulations governing licensed practice in the State of Hawaii.

Potential Benefits

- Increased access to care.
- Increased convenience.
- Possible cost savings by eliminating the costs for travel and time.
- Barrier removal. Those who struggle with certain conditions might feel less threatened by online counseling than by in-person sessions.
- Accommodates stigma and/or privacy concerns inherent in in-person services.
- May allow for more authentic emotional expression.
- Equal effectiveness. The growing body of research on TMH indicates that it (specifically the use of videoconferencing) can be an effective mode of treatment with equivalent therapeutic alliance ratings to face-to-face therapy.

Potential Risks

- Increased difficulty assuring confidentiality and verification of student's identity.
- Cannot guarantee privacy and confidentiality. There is potential for people to overhear sessions if both counselor and student are not in a private place.
- Potential for interception of sensitive data.
- Potential for technical difficulties and service interruptions to occur.
- Increased difficulty with unexpected crisis intervention. Counselor and student must develop an emergency plan and procedures.
- Inability to see context of communication. The ability to see the details of facial expressions and nonverbal communication is limited. More than 80% of communication is nonverbal.
- Increased difficulty administering assessment tools.
- Lack of infrastructure and technological competence.
- Limited access to needed equipment and private space.

Confidentiality

The extent of confidentiality and the exceptions to confidentiality that are outlined in the Informed Consent still apply in TMH services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telehealth than in traditional in-person therapy. To address some of these difficulties, your Counseling and Psychological Services (CAPS) provider may create an emergency plan before engaging in telehealth services. You will need to provide an emergency

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contact in case of a disruption or technological connection failure. Your CAPS therapist will try to reconnect with you, do not contact them. If you are in need of immediate and urgent assistance call Public Safety at (401)454-6666 or go to your nearest emergency room.
If the session is interrupted and you are not having an emergency, disconnect from the session and your CAPS provider will wait two (2) minutes and then re-contact you via the telehealth platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call the CAPS office at (401)454-6637 and leave a message, your provider will call you back.

I agree to participate in TMH services only while in a room or area where other people are not present and cannot overhear the conversation.

I agree that none of the sessions will be recorded.

I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of Kaua'i Community College, Hale Malama Care TMH services. I hereby give my consent to authorize Kaua'i Community College, Hale Malama Care Center counselor to evaluate, counsel, and/or refer me to others as needed.

I have read the above information and understand the risks and benefits of and special considerations for TMH.

I have had the opportunity to discuss any questions regarding the above information.

Student Signature: ____ *Date:* ____________________

Counselor Signature: ____ *Date:* ____________________