

CSUB Counselor Training Clinic

INFORMED CONSENT TO TREATMENT AND TO BE OBSERVED AND/OR VIDEO RECORDED

Informed Consent: The following information is being offered to help you decide if you want to participate in counseling with graduate students and interns in the University Counselor Training Clinic. Your counselor will help you understand any information that is not clear or answer any questions that might assist your decision. These counselors are not yet licensed. Counseling is under supervision of faculty members licensed in Marriage and Family Therapy.

Counseling can help you resolve the concerns that brought you to therapy as it provides a safe place to talk about and work through challenges. The process sometimes involves tolerating uncomfortable feelings, discussing unpleasant and painful events, and facing fears, anxiety, anger, and helplessness. For most people, counseling does not entail more serious risks than these. Throughout the process, your counselor will support you.

You have the right to have things discussed kept in confidence. Information revealed by you will be kept in strict confidence and will not be disclosed to any person not officially involved in the training effort of the Clinic or outside agencies without your written permission. However, you should also know that there is certain information that the counselor is required by law to reveal to appropriate authorities – with or without your permission. The situations in which the counselor is required to disclose are:

- When any person under the age of 18 is neglected, physically or sexually abused (including downloading, streaming, or accessing - through any electronic or digital media - a child engaging in an act of obscene sexual conduct).
- When you are an immediate danger to yourself or to others (suicide, homicide, or when grave bodily harm may occur).
- When a court of law issues a legitimate subpoena.
- When a person 65 years and older, or a dependent adult is physically abused, abandoned, isolated, financially abused, or neglected.
- When the federal government requests access to your file under the U.S. Patriot Act.

_____ (initial) I understand that my counselor will not write letters of any kind on my behalf. Receipts provided will be the only proof of my attendance and payment.

_____ (initial) I understand that attending counseling while under the influence of any mood altering substance prevents progress. I further understand that if I arrive the Clinic while under the influence, my counselor will end the session and reschedule for a future date. I also understand that a repeat occurrence will result in termination of services (with referrals).

_____ (initial) I understand that any violent or threatening behavior I exhibit in the Clinic may result in termination of services and a police report.

_____ (initial) I understand that no unattended minors can be left in the waiting room.

Fee and Payment: \$25.00 fee is charged for the first visit and \$15.00 fee is charged for any of the following visits.

- The fee is for a 50 minute session.
- Payment is expected at the time of service.
- 50% of my regular session fee will be paid for late cancellation (less than 24 hours) or failure to attend (serious illness excepted).
- Returned checks will be subject to a bank processing fee. Future checks will be refused by the Clinic.

NO EMERGENCY SERVICES: The Clinic does not provide emergency services or 24-hour care. If you need immediate assistance, call 9-1-1 or the Kern County Mental Health Psychiatric Evaluation Center at 1-800-991-5272.

Consent to be Observed and/or Video Recorded: The primary use of recordings and observations is to increase the effectiveness of counselor training by provision of instruction and feedback. Information from these recordings may be used for the purpose of treatment, education, and/or research in the interest of the advancement of mental health training. No real client names shall be used for any purpose other than those specified above. Recording and/or utilization of information under the terms of this signed consent shall not be subject to legal action.

I agree to hold harmless and indemnify the Trustees of the California State University and its respective officers, officials, employees, representatives, and volunteers, from, or in connection with my participation in the Clinic's counseling sessions and related activities, including but not limited to liability, which results from my own negligence or noncompliance with the procedures of the Clinic.

Signing this form is an acknowledgement of having read and discussed the information and agreed to the conditions described above.

Client Signature _____ Name _____ Date _____

Parent/Guardian Signature _____ Name _____ Date _____

Counselor Signature _____ Name _____ Date _____