Ottawa University
Prepare for a Life of Significance™

Counseling Center

Written Informed Consent for Treatment

I, ____ born on ________________, hereby authorize services at OUAZ Counseling Center.

- We encourage students to actively participate in the treatment planning process and determining the care that may be most helpful to accomplish their goals. We encourage students to discuss any concerns about the therapeutic process, including treatment intervention and progress.
- The **therapeutic relationship** involves mutual respect and safety between the student and the counselor.
- **Confidentiality** is an essential component for effective mental health treatment All counseling records are maintained separately from all academic, administrative, disciplinary and medical records, unless otherwise noted. No information about a student's contact with OUAZ Counseling Center is released without the knowledge and written consent of the student; however, there are occasions when we are allowed to break confidentiality. Arizona law and professional ethics allow the treating provider(s) to breach the **limits of confidentiality** in the following circumstances:
  - In a situation where you pose an immediate threat to yourself or anyone else's safety, we are required to take action to prevent harm.
  - If a situation is discussed where a child, elder, or a person unable to care for themselves may be in danger of abuse or neglect, we are legally required to report this to the proper authorities.
  - If a court order may also be issued by a judge and may require information about your counseling be submitted.
- **In case of emergency**, where there is a concern for your safety and we are unable to contact you, your emergency contact and/or necessary authorities (including but not limited to Student Affairs staff and campus security) will be contacted. If an emergency medical/psychological evaluation is deemed necessary, contact will be made with your emergency contact, campus security, appropriate medical facility and the CARE team.
- In addition, the counselor may share information as permitted within their ethical and legal guidelines, and only for the purpose of consultation, treatment planning, and diagnosing, and while maintaining the student's confidentiality. I understand the information will only be shared as needed to ensure that the student is receiving the best services.
- With respect to **electronic mail** (email), I know that it is not a confidential means of communication. I understand email is not an appropriate way to communicate confidential, urgent, or emergency information. The counselor will not engage in therapeutic work via email or text messaging. Electronic messaging can be used for coordination of treatment including scheduling appointments and following up as necessary.
- **Social media**: The counselor will not accept friend or contact requests from current or former clients on any social media networking site (Facebook, Instagram, LinkedIn, etc.) in order to respect confidentiality and privacy. This will also help to maintain the boundaries of the therapeutic relationship.
- Please understand that we are unable to provide continuous 24-hour crisis services. In the event of a **medical emergency or an emergency involving a threat to your safety or others**, please call 911 to request emergency assistance or go to the nearest emergency room.

Counseling services are free of charge for OUAZ students. Visits usually last 45 minutes. The first session is an opportunity to gather information about student's history, create goals related to treatment and review/clarify any questions about the treatment process. In most cases the student will continue with the OUAZ counselor, however, there are occasions when a student will be referred for services at an outside agency, as it would better serve their mental health needs.

- I have voluntarily chosen to participate in the services provided at Ottawa University Counseling Center. I understand the purpose of the services rendered and have had the chance to ask questions and receive clarification about the services being provided, the treatment process and therapeutic alliance.
- I understand the limits of confidentiality. The release of information has also been explained to me.
- A copy of this agreement can be provided to me upon request.

______________________________ ______________
Student Date

______________________________ ______________ (See attached page for parent/legal guardian consent, if applicable)
Clinician Date

CONSENT TO TREAT A MINOR

I ________________________________, do hereby consent to the assessment and treatment of
(Parent/Legal Guardian/In Loco Parentis)

__________________________, DOB ____/____/____, provided by OUAZ Counseling Center.
(Student's Name)

By signing below, parent/legal guardian understands that the facility will make no effort to notify them for further consent related to services after the receipt of this consent.

This written authorization may be withdrawn at any time by providing notice in writing to:

OUAZ Counseling Center
15950 N. Civic Center Plaza
Surprise, AZ 85374

___________________________________ ___________________________
Parent/Legal Guardian/In Loco Parentis Signature Date

___________________________________ ___________________________
Witness Date