# ISU-Pocatello Counseling Center

1400 E. Terry Dr., Bldg. 63
Garrison Hall, 7th Floor
Pocatello, ID 83209
208.240.1609

Welcome to the ISU-Pocatello Counseling Center. The following notice is an introduction to your rights and responsibilities as a client at the clinic. The ISU-Pocatello Counseling Center serves dual functions: to provide counseling for the community and to aid in the professional development of counselors and supervisors. All counseling is facilitated by graduate students at the Masters level who are supervised by a counseling professor. *All counseling sessions at the ISU-Pocatello Counseling Center are video- taped for supervisory and educational purposes*

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## CLIENT INTAKE INFORMATION

*Please answer all information as completely as possible. Information given is strictly confidential within the limits of the law and beneficial in providing the best possible service. Feel free to ask for assistance. Your counselor will discuss your responsibilities with you in your initial session.*

*Idaho State University Counseling Clinic does not get involved with any legal or disability-related issues or claims.*

## CLIENT INFORMATION

Client Name: Today's Date:

Date of Birth: Age: Preferred Pronoun (eg: she, he, ze, they):

Self-identified Gender: Sexual Orientation: Primary Language:

Parent/Guardian Name (If client is a minor):

_____

Client Address:

Cell phone: _____
May call: Yes No
May leave message: Yes No

Home phone: _____
May call: Yes No
May leave message: Yes No

Email: _____
May email: Yes No

Current Occupation: _____ Level of Education Completed: _____

Relationship status (ex: Single, married, divorced, separated, significant relationship/s, etc.): _____

In case of emergency, please contact: _____
Name Relationship Phone

Have you received prior counseling? □ No □ Yes If yes, please explain: _____

_____

Was it helpful? □ No □ Yes Please explain: _____

## PRESENTING PROBLEMS AND CONCERNS

Please describe your reason for seeking counseling at this time and how you will know if it is working:

Have you ever or are you currently contemplating ending your life? □ No □ Yes

Has anyone in your immediate family attempted or completed suicide? □ No □ Yes If yes, when?_____

**Please circle any of the following that are currently troubling you:** For all of those which you circle, please indicate on a scale from 1 to 10, with 10 being significant, how severe you feel this issue is in your life at the present time.

| | | | |
|---|---|---|---|
| Abuse | Family | Motivation | Stress |
| Alcohol/Drug use | Fear | Perfection | Study habits |
| Anger/Rage | Finances | Procrastination | Suicidal thoughts |
| Anxiety/Panic | Friends | Relationship | Test anxiety |
| Appearance/Weight | Grades | Sadness | Time management |
| Assertiveness | Grief | Self-esteem | Trust |
| Boredom | Guilt | Sexual harassment | Unhappiness |
| Career | Helplessness | Sexuality | Worry |
| Dating | Homesickness | Shyness | Other: |
| Depression | Hopelessness | Sleep | Other: |
| Eating problems | Loneliness | Stalking | Other: |
| Expressing feelings | Meeting people | Staying in school | |

**Present Family/ Living Situation**

Please identify the people currently living with you and the nature of your relationship.

| | Name | Age | Relationship | Currently this relationship is: Good, neutral, conflicted, etc. |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |

## HISTORY

**Health**

Are you currently under the care of a medical doctor or other medical health professional: □ No □ Yes

Name of Primary Care Physician:_____ Physician Phone : _____

Are you currently taking any prescription medications, vitamins or herbal supplements ? □ No □ Yes
If yes, please list each medication below

_____ mg ____ Prescribed for: _____ By: _____

_____ mg ____ Prescribed for: _____ By: _____

Do you have any allergies? □ No □ Yes If yes, please list: _____

Date of last physical exam: _____ Any significant results: _____

Physical disability: □ No □ Yes Chronic illness: □ No □ Yes

If yes to either, please explain: _____

Prior psychiatric hospitalizations? □ No □ Yes If yes, when: _____

Do you currently exercise: : □ No □ Yes If yes, please indicate what type and how many times per week:_____

Are you having any problems with your sleep habits? □ No □ Yes If yes, please explain:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other _____

Are you having any difficulty with appetite or eating habits? □ No □ Yes If yes, please explain:

Have you or are you currently using any of the following substances?

| Substance | Past or Present use? | Frequency/Amount | Method of use | Level of concern |
|---|---|---|---|---|
| Caffeine □ No □ Yes | | | | |
| Alcohol □ No □ Yes | | | | |
| Tobacco □ No □ Yes | | | | |
| Recreation or Street Drugs □ No □ Yes (Please list) | | | | |

**Legal**

Have you ever been the victim of a crime? □ No □ Yes If yes, please list date and briefly describe:

Are you currently involved in divorce or child custody proceedings? □ No □ Yes If yes, please explain:

Have you ever been convicted of a misdemeanor or felony? □ No □ Yes If yes, please explain:

**Cultural Beliefs Affecting Treatment**

What culture do you identify with?

**Strengths and Interests**

What are your strengths and interests?

## GOALS

What are the goals you hope to achieve in counseling:

1.

2.

3.

Is there anything you would like to add that I have not asked which you would like to include?

Client Signature: _____ Date: _____

Parent/Guardian Signature if under 18: _____ Date: _____

Parent/Guardian Signature if under 18: _____ Date: _____

Thank you for your time!

**Fee for Service**: This agreement shows my commitment to pay for services. I agree to pay in cash or check, $20.00 per session for Individual Therapy. I understand that payment is due at the beginning of each session and accept that I am fully responsible for this fee.

**Limitations of Service Provided by ISU-Pocatello Counseling Center**: I understand that ISU-Pocatello Counseling Center is a training facility and therefore some counseling services are not provided. Services not provided include, but are not limited to, issues pertaining to parental fitness and custody, court or legally mandated mental competency evaluation, counseling pertaining or associated with criminal proceedings. Further, I understand that other services may not be provided based on the clinical judgment of my student counselor's supervisor and/or faculty of Idaho State University. I understand that, in the event that such services are required, I will be provided with a list of referrals.

My initials below indicate I have read the following materials, which have been provided to me by this student counselor:

1. _____ Informed Consent 2. _____ Permission to Record Sessions

My signature below indicates that I understand and agree with all of the above points.

_____ _____

Client Signature Date

I, the student counselor, have discussed the issues above with the client. My observations of this client's behaviors and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Student Counselor Signature Date

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## Agreement by Parent/Guardian for Counseling with a Minor

I, _____, the rightful parent/legal guardian of _____, give my permission for this minor to receive the following counseling services from ISU-Pocatello Center as represented by: _____.

The fees for these services will be $ 15.00 per session with payment due at the beginning of each session. The ISU-Pocatello Center policies concerning missed appointments have been explained to me. I have been told about the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his or her family.

**Confidentiality**: I understand that, under Idaho law, minors do not have a legal right to confidentiality. I also understand that confidentiality is important for this minor to feel safe in the therapeutic relationship. I therefore agree to work with this counselor so as to achieve a level of confidentiality that is necessary for this minor's therapeutic progress.

I understand that ISU-Pocatello Center abides by the ethical codes established by the American counseling Association as well as the rules and statues governing the practice of counseling in the State of Idaho. These ethical codes and legal statues require counselors to report to responsible persons or state agencies when clients indicate any of the following situations:

- **That the client intends to harm self**
- **That the client intends to harm someone else**
- **Information as to direct involvement in child abuse or neglect**
- **Information as to direct involvement in abuse of the elderly or disabled**

I understand that the counselor will keep me apprised of this minor's progress and that this counselor is willing to meet with me to discuss any concerns and or questions that I have. Progress in this minor's treatment will be reviewed on or about this date: _____ and on a regular basis after that.

**Videotaping:** I give my permission for the counselor to **videotape** the sessions with this minor for personal review, supervision, and limited educational purposes. All who may view these videotapes are bound by the legal framework of privacy and confidentiality. I understand that any information in these recordings that could identify me or this minor in any way will not be published or given out without my written consent. I understand that all video recordings of these sessions will be destroyed at or before the conclusion of counseling.

My signature below means that I understand and agree with all of the points above.

_____

Signature of Parent/Guardian Date

_____

Signature of Minor Date

I, the counselor, have discussed the issues above with the minor client's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the minor client's treatment.

_____

Signature of Counselor Date

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**INFORMED CONSENT**
**Please read every section and initial each line.**

_____**What to Expect:** Appointments are 50 minutes in duration, once per week, at a regularly scheduled time, although schedules may be more or less frequent as needed. You are expected to arrive on time and your session cannot be extended due to late arrival. If you need to cancel your appointment please leave a message on the clinic voicemail, (208) 240-1609, at least 24 hours before your scheduled session.

The ISU Pocatello Counseling Clinic is open when school is in session during the fall, spring, and summer semesters and is not staffed during school holidays. This may mean you will not be able to see your student counselor for one to four weeks between semesters. Your student counselor will work with you in advance to plan for these breaks and provide referrals if needed.

You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin. Your student counselor is a safe person to talk with about any of these topics. The ISU Pocatello Counseling Clinic is a designated Safe Zone; a program designed to increase awareness, affirmation, and acceptance of those who identify as lesbian, gay, bisexual, trans, and/or experience their gender identity and/or sexual orientation on a continuum.

The ISU Pocatello Counseling Clinic is a teaching facility made up of master's and doctoral level students working towards their degrees. As students progress or graduate they will no longer continue to work in the clinic. Student counselors will inform you in advance of any changes in their availability. If the need arises for the student counselor to transition out of the clinic, they will work closely with you to create an individualized plan to support you with your goals for counseling.

_____**Risks and Benefits:** There is a possibility of risks and benefits which may occur in counseling. Counseling may involve the risk of remembering unpleasant events; arouse strong emotional responses; and impact client's relationships. The benefits from counseling may be an improved ability to relate with others; develop a clearer understanding of self, values, goals; increased academic productivity; and an ability to deal with everyday stress. Speaking honestly about your experience will increase your student counselor's ability to assist you.

_____**Limitations of Service:** The student counselors at the ISU Pocatello Counseling Clinic are not licensed counselors. All are master's level and/or doctoral students working under the supervision of licensed counselors in faculty or doctoral student positions. Your student counselor is unable to diagnose, provide insurance billing, evaluate for parental fitness and custody, court or legally mandated services, or offer counseling pertaining to criminal proceedings.

_____**Payment and Billing:** Payment is due at the beginning of each counseling session and your student counselor is unable to see you without payment. We are unable to bill insurance at ISU Pocatello Counseling Clinic. If you are unable to afford the fee please discuss this situation with your student counselor and we may be able to provide sliding scale, or pro bono services, on a limited basis. You may not carry forward a credit; please pay for each counseling session individually.

_____ **Crisis Communication:** To contact your student counselor please call the Clinic voicemail, (208) 240-1609, and leave a message. Your student counselor will return your call in a timely manner. We are unable to provide emergency services. If you have an emergency, please call 911 or go to your nearest emergency room.

_____ **Electronic Communication:** PCC staff will not interact with clients via social media. Any social media presence by PCC or staff members will not be continuously monitored and will not be utilized as a means of communication between client and clinician. In addition, PCC staff will not utilize text messaging, instant messaging, Snapchat, or similar communications to interact with students. Students may opt to be contacted by a voice phone call or, by client request, email. Email will only be used for scheduling purposes and not as a form of communication about therapeutic issues or for crisis intervention. Staff do not monitor email outside of regular business hours and may not check email consistently throughout the day.

**I have read and understand the ISU Counseling Clinic Informed Consent.**

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (Required if client is a minor) Date

_____ _____
Student Counselor Signature Date

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# Limits of Confidentiality in Counseling

The ISU-Pocatello Counseling Center abides by the ethical codes established by the American Counseling Association as well as the rules and statues governing the practice of counseling in the State of Idaho. These ethical codes and legal statues require counselors to report to responsible persons or state agencies when clients indicate any of the following situations:

- **That the client intends to harm self**
- **That the client intends to harm someone else**
- **Information as to direct involvement in child abuse or neglect**
- **Information as to direct involvement in abuse of the elderly**
- **Information as to direct involvement in abuse of the disabled**

Confidentiality is also limited by the use of supervisory sessions involving practicum students, interns and supervisors. Confidentiality may be limited as mandated by the courts or, in the case of minors, when parents may have access to counseling information.

By signing below, I indicate that I understand my limits of confidentiality and I am aware of the certain situations where the counselor must breach my right to confidentiality in the counseling relationship with or without my permission.

_____

Client Date

_____

Parent/Guardian (if client is a minor, a parent/guardian signature is required) Date

_____

Counselor Date

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## PERMISSION TO RECORD

I, _____, give _____,
**(Client* or Client's Parent or Guardian)** **(Student Counselor)**

a student in the Department of Counseling at Idaho State University, permission to audio/video record our counseling sessions, and/or have visual records and observations of me uploaded to a secure webhosting service** for storage and viewing. I understand that the contents of the recordings may be reviewed with a training supervisor, counseling faculty, supervision group and/or Oral Exam committee members. I have been informed that the contents of the recordings are considered confidential and will not be shared in any other way than described above without my written permission.***

I understand and agree to the use of these recordings and observations to increase the effectiveness of the student's counseling by provision of instruction and feedback. Furthermore, I understand that my name shall not be used in connection with these recordings. I agree that the material from these recordings cannot and will not be used for any purpose other than those specified above.

I understand that my counselor is a graduate student in counseling, is not yet licensed and is under the supervision of a qualified supervisor.

_____ _____
Client Signature Date

_____ _____
Signature of Parent/Guardian if Client is a minor Date

*The term "client" as used herein refers to any person receiving services

**The secure webhosted service is titled Panopto. The video sessions will be stored upon an online storage drive and made viewable to only the counselor in training, their ISU counseling department supervisor, their ISU faculty supervisor, and field supervisor. Permission to view the video will require a password known only to the counselor in training, their ISU counseling department supervisor, and their ISU faculty supervisor. The recorded video sessions will be stored for the duration of the current semester then deleted entirely from the online storage drive. At anytime you the client can request that the video be deleted or specify videos you do not wish to be uploaded to the online storage drive.

***Clients have the right to confidentiality. Information shared with permission will be kept confidential within the professional setting. There are, however; legal exceptions to this right; information must be shared under the following circumstances:
(a) when ordered by the court, or
(b) when the counselor and a training supervisor determine that an individual may present a threat to self or others.
(c) Idaho law requires the report of any known or suspected instance of child or adult abuse or neglect.
It is understood that all information disclosed within these sessions will otherwise be kept confidential and will not be released to anyone outside of the agency without written permission, except where disclosure is required by law.
NOTE: A signed and dated permission form MUST be obtained for each client, prior to any recording (audio or video).

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**PANOPTO FAQ**

**What is Panopto?**
Panopto is video content management system (VCMS). This means that users* of Panopto are able to record and or upload video sessions to an online storage system.

**How does Panopto work?**
Panopto allows users to log in to a password protected webhosted service to upload videos via a secure connection. Users are assigned a folder to which they can save their videos. These videos can then be played back online.

**How does ISU's Department of Counseling protect the video sessions?**
We secure videos through a combination of methods. Our first method is to assign each user a unique password that only allows them access to their folders, videos, and recording capacity. Second, we restrict the permission to view each user's folder. For example, an intern's folder will only be viewable by the user, their doctoral supervisor, and their faculty supervisor. Third, we will be deleting videos once they have been viewed by the faculty supervisor or the current semester of study expires. Lastly, we enforce strict policies contained within our department's student manual that specifies the locations that videos may be viewed outside of supervision. For example, users are not permitted to play back videos in public spaces or in the presence of others not associated with their supervision. The viewing of videos is intended to be a private activity.

Your understanding and comfort using Panopto is important to us and we wish to continue providing education and training on how to make the use of Panopto as successful as it can be. If at anytime you have questions, please feel free to contact the following individuals

ISU Meridian Department of Counseling's Clinic Director. Dr. Shawn Parmanand: (208) 282-1431, shawnparmanand@isu.edu
ISU Department of Counseling's Chair. Dr. David Kleist: (208) 282-4315, kleidavi@isu.edu
ISU Department of Counseling Internship Coordinator. Dr. Randy Astramovich: (208) 282-3075, randyastramovich@isu.edu
ISU Department of Counseling Panopto Technology Coordinator. Chad Yates: (208) 282-3158 yatechad@isu.edu

**Is Panopto secure?**
Panopto uses SSL** in the web interface to encrypt all sensitive user information. The Panopto server uses password hash checking. Passwords are not stored as plaintext. Although using a server-based video content management system is never 100% safe we feel the use of this system helps us to guarantee a level of security unreachable before now.

**Definitions**
*Users include the following: counseling master's students enrolled in practicum and internship, ISU counseling department supervisors (assigned doctoral students), and ISU faculty members.

** SSL (Secure Sockets Layer) is the standard security technology for establishing an encrypted link between a web server and a browser. This link ensures that all data passed between the web server and browsers remain private and integral.