ISU-MERIDIAN COUNSELING CLINIC
Department of Counseling ISU-Meridian | Health Science Center
1311 E. Central Drive, Meridian, ID 83642 | (208) 373-1719

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) 373-1719, at least 24 hours before your scheduled session.

The ISU Meridian 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 Meridian 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 Meridian 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 Meridian 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 Meridian 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) 373-1719, 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: MCC staff will not interact with clients via social media. Any social media presence by MCC or staff members will not be continuously monitored and will not be utilized as a means of communication between client and clinician. In addition, MCC 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.

School Environment: The ISU Meridian Counseling Clinic shares a building with Renaissance High School and the West Ada School District Offices. The school is required to conduct periodic fire drills and lock down procedure drills. In the event of a fire drill an alarm will sound and you will be required to exit the building and gather at the designated assembly location in the parking lot. You will be permitted to return to the building after a short period. In order to maintain confidentiality your student counselor will not discuss any issues outside of the session. In the event of a lock down drill you will be asked to stay in the counseling room until the all clear is given. In the event of a real lock down emergency you are asked to use good judgement and either remain in the locked suite or quickly exit should you feel this is the safest course of action.

Due to the clinic’s proximity to Renaissance High School, ISU Meridian Counseling Clinic is unable to offer services to registered sex offenders or individuals with a history of violence. Additionally, guns and weapons are not permitted on the premises.

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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__________________________  ____________
Client Signature              Date

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

__________________________  ____________
Student Counselor Signature  Date
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Department of Counseling ISU-Meridian | Health Science Center
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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.

_________________________________________ Date
Client Signature

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

*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).

[X] Client Copy [ ] File Copy

Page 1 of 2
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 Directo. Dr. Logan Lamprecht: (208) 373-1944, lamploga@isu.edu
ISU Department of Counseling’s Chair. Dr. David Kleist: (208) 282-4315, kleidavi@isu.edu
ISU Department of Counseling Internship Coordinator. Steven Moody: (208) 282-2304, moodste2@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.
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.***

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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

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(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.
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AGREEMENT FOR INDIVIDUAL COUNSELING

I, ________________________________, the client, agree to meet with the Student counselor
named below at the appointment times and places we agree on, starting on _________, 20____.

I believe I understand the basic ideas, goals, and methods of this counseling. I have no important
questions or concerns that the student counselor has not discussed. In my own words, I understand
the following:

With enough knowledge, and without being forced, I enter into treatment with this student
counselor, I will keep my student counselor fully up to date about any changes in my feelings,
thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work
them out in my long-term best interest.

Confidentiality: I understand that ISU-Meridian Center abides by the ethical codes established by
the American Counseling Association as well as the rules and statutes governing the practice of
counseling in the State of Idaho. These ethical codes and legal statutes require student 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 also understand confidentiality is limited by the use of supervisory sessions involving practicum
students, interns and supervisors. In signing below, I acknowledge that I understand my limits of
confidentiality and I am aware of the certain situations where the student counselor must breach my
right to confidentiality in the counseling relationship with or without my permission.

Duration of Treatment: Progress will be evaluated every 90 days and parts of this agreement may
change as needed. Our goals may have changed in nature, order of importance, and/or definition. If
you are unhappy with what is happening in your counseling sessions, please bring these concerns up
with your student counselor, or speak with a supervisor. Such comments will be taken seriously and
handled with care and respect. While you have the right to end the counseling relationship at any
time, we encourage letting your student counselor know in advance if you plan to terminate
services.

Counseling Records: Counseling records are not part of academic records, and no one, other than
MCC Staff, have access to them except under the limits of confidentiality. Complete records are
maintained for seven years from the date of our last contact with you. Upon your written request,
we will provide appropriate written information regarding your counseling to another licensed
mental health care provider or physician of your choice. If you request a release of information to
any other individual, we will request personal contact with you in addition to the written release.
Your counseling record with us is maintained in both paper file and electronic file formats. Both
formats are considered confidential, and access to them is restricted to the conditions previously
stated.
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-Meridian Counseling Center: I understand that ISU-Meridian 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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I, _____________________, the client, agree to meet with the Student counselor named below at the appointment times and places we agree on, starting on _______, 20____.

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Counseling Records: Counseling records are not part of academic records, and no one, other than MCC Staff, have access to them except under the limits of confidentiality. Complete records are maintained for seven years from the date of our last contact with you. Upon your written request, we will provide appropriate written information regarding your counseling to another licensed mental health care provider or physician of your choice. If you request a release of information to any other individual, we will request personal contact with you in addition to the written release. Your counseling record with us is maintained in both paper file and electronic file formats. Both formats are considered confidential, and access to them is restricted to the conditions previously stated.
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Client Signature                                          Date

________________________________________________________________________

Student Counselor Signature                               Date

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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

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Today’s Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Age:</td>
</tr>
<tr>
<td>Preferred Pronoun (eg: she, he, ze, they):</td>
<td></td>
</tr>
<tr>
<td>Self-identified Gender:</td>
<td>Sexual Orientation:</td>
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<tr>
<td>Parent/Guardian Name (If client is a minor):</td>
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</tr>
<tr>
<td>Cell phone:</td>
<td></td>
</tr>
<tr>
<td>May call: Yes No</td>
<td></td>
</tr>
<tr>
<td>May leave message: Yes No</td>
<td></td>
</tr>
<tr>
<td>Client Address:</td>
<td></td>
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<tr>
<td>Home phone:</td>
<td></td>
</tr>
<tr>
<td>May call: Yes No</td>
<td></td>
</tr>
<tr>
<td>May leave message: Yes No</td>
<td></td>
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<tr>
<td>Email:</td>
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<tr>
<td>May email: Yes No</td>
<td></td>
</tr>
<tr>
<td>Current Occupation:</td>
<td>Level of Education Completed:</td>
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<tr>
<td>Relationship status (ex: Single, married, divorced, separated, significant relationship/s, etc.):</td>
<td></td>
</tr>
<tr>
<td>In case of emergency, please contact:</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Relationship</td>
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<tr>
<td>Have you received prior counseling? □ No □ Yes</td>
<td></td>
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<tr>
<td>If yes, please explain:</td>
<td></td>
</tr>
<tr>
<td>Was it helpful? □ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Please explain:</td>
<td></td>
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</table>

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.

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

Present Family/ Living Situation
Please identify the people currently living with you and the nature of your relationship.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Currently this relationship is: Good, neutral, conflicted, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>4</td>
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<tr>
<td>6</td>
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</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Past or Present use?</th>
<th>Frequency/Amount</th>
<th>Method of use</th>
<th>Level of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeine</td>
<td>□ No □ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>□ No □ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>□ No □ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreation or Street Drugs</td>
<td>□ No □ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Please list)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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!