



Uniformed Services University

USU Student Counseling Center Confidentiality Policy

Confidentiality is an ethical standard that protects clients from the disclosure of information without their consent. Client contacts with the Student Counseling Center (SCC) are confidential. We will not provide information about clients to friends, partners, faculty, parents, employers or anyone else outside of the SCC Staff without expressed consent.

The Counseling Center will release information from counseling sessions to third parties only at the request of the client. The “Authorization to Release Professional Information” form, signed by the client and a witness, will be used for that purpose. The client must give informed consent and therefore his/her counselor will discuss, prior to release, the information to be released, to whom, and for what purpose. The client will also be advised about the possible effects of disclosure.

Exceptions:

- When the Counseling Center believes that a client poses a clear and present danger of harm to himself/herself and/or others (verbal threat, action, or possession of a prohibited weapon or prohibited device), the Counseling Center may selectively release information, without the client’s consent, to aid in the care and protection of the client or endangered others.
- When the Counseling Center has reasonable cause to suspect that a child (a person under 18 years of age) has been subjected to child maltreatment, which may involve abuse, sexual abuse, neglect, sexual exploitation or abandonment as defined by Maryland Law, the Counseling Center may selectively release information, without the client’s consent, to aid in the care and protection of a child. The Counseling Center is further required by Maryland Law to report this information to the Department of Human Services.
- When the Counseling Center has reasonable cause to suspect that an adult (a person 18 years of age or older) through abuse or neglect, is in imminent risk of death, or bodily harm and does not comprehend the nature and consequence of remaining in that situation or condition, then the Counseling Center is required to report this situation to the Maryland Department of Human Services.
- When the Counseling Center has reasonable cause to suspect significant impairment that would prevent the Client from performing essential job functions required by their position or military fitness for duty regulations.

E-mail Communication:

E-mail is an important means of communication. However, e-mail is not a secure means to transmit confidential information. Therefore, the Counseling Center will use e-mail to communicate with clients only (a) in response to the client’s initiation and/or (b) with the client’s consent to send messages to their e-mail address as documented on their signed Intake Form.

Client files:

Client files are not a part of any permanent record at the University, but are the property of the Counseling Center. A client’s file is maintained at the Counseling Center for a period of seven (7) years from the date of last contact. A client’s file is destroyed after this seven (7) year period.

Clients may review their records in the presence of a Counseling Center staff member, upon written request. The request and fact that a review occurred will be noted in the client’s record. Clients may receive copies of their record unless the Counseling Center, upon review, believes disclosure would be detrimental to the client’s health or well-being.

Client session notes are kept and stored on paper or electronically and maintained in the client’s file. The entire file including client demographic information and other personal information is maintained in a secured location dedicated to the Counseling Center’s needs. Compiled information when retrieved is used for summary report purposes and does not identify clients by name.

The client file of a person who is not a student, including but not limited to, a staff member, faculty member, dependent etc., will be entered into Walter Reed National Military Medical Center’s electronic health record system.

Disclosure of Client Records:

Maryland law recognizes the privilege that attaches to the counselor-client and psychologist-client relations. The privilege is extended only to licensed counselors and psychologists. Should the Counseling Center receive a subpoena for client records, university legal counsel will be consulted prior to taking any action. Clients will be notified in advance, if at all possible, of any compliance with a court order, state or federal law that might require disclosure of client records.

Concerns and Complaints: The Counseling Center staff strives to provide counseling that demonstrates respect for every client, treats all with dignity, and is sensitive to the diversity that is present in those whom we serve. If your counselor does not meet these standards in counseling with you then we encourage you to let us know.

First, you may take your concern directly to your counselor and attempt to resolve the issue/s with him/her. If that interaction does not result in a satisfactory solution - or you are uncomfortable speaking directly with your counselor about your concern - then request to speak with the Director of the Counseling Center (insert Keller's number here) Student Health Center. The Director will arrange a meeting with you to review the issue/s and attempt to find a suitable resolution.

If the Director of the Counseling Center is your counselor and your complaint is about them, you may contact the (Insert point of contact here). They will arrange a meeting with you to review the issue/s and attempt to find a suitable resolution.



USU Counseling Center
University Family Health Center - A 1034
4301 Jones Bridge Road Bethesda, MD 20814

Informed Consent for Personal Counseling

I, _____, have voluntarily decided to seek personal counseling from the USU Counseling Center. I understand the following points about the treatment I will receive:

- 1) The treatment that I receive is considered confidential. I have been informed about the exceptions to confidentiality and presented with a full copy of the USU Student Counseling Center's Confidentiality policy.
- 2) Services are provided by staff members who are licensed psychiatrists, psychologists, social workers, and counselors. Staff member credentials are kept on file and I may request to view those of my counselor.
- 3) The staff member who provides my personal counseling will offer treatment that is within the scope of his/her competence to provide.
- 4) Treatment will be based upon the particular issues, concerns, or problems which the staff member and I agree to work on.
- 5) Treatment goals are therapeutic in nature. If I have issues that have resulted in **command directed or court-ordered** counseling, have legal implications, and/or require formal evaluation, then I will be referred to off-campus mental health professionals for relevant services.
- 6) The treatment will consist of methods (strategies, techniques, and interventions) that are accepted in the mental health field as appropriate for the problems that I present. When there are limitations or foreseeable harm that could occur with a specific method, the staff member will explain them to me.
- 7) The staff member believes the proposed treatment can improve my condition and enable me to achieve my goals but he/she cannot guarantee the results.
- 8) The staff member may recommend that I complete a psychological test/inventory as a component in my treatment. He/she will explain the purposes and uses of the test(s). I may choose whether or not to take them. The staff member will provide an interpretation of the results for any test that I complete.
- 9) There is no direct charge or cost for treatment services.
- 10) I can choose to discontinue my personal counseling at any time.

Upon consideration of the information presented to me, I authorize the staff member to provide me with personal counseling and to use the methods that he/she believes clinically appropriate. I make this decision to accept the proposed treatment knowingly, voluntarily, and without coercion.

Signed: _____ Date: _____



USUHS Counseling Center

University Family Health Center - A 1034
4301 Jones Bridge Road Bethesda, MD 20814

CONFIDENTIAL INTAKE SHEET

DATE: _____ DOD ID Last 4# _____

NAME _____ (_____)
Last First M. Preferred/Nickname (if applicable)

Current Address _____

City _____ State _____ Zip _____

Cell Phone _____

Alternate Phone (Whose #?) _____

Home Address (if different) _____

City _____ State _____ Zip _____

Email _____

May we CONTACT you at:			May we leave a MESSAGE on your:		
Cell Phone?	Yes _____	No _____	Cell Phone?	Yes _____	No _____
Alternate Phone?	Yes _____	No _____	Alternate Phone?	Yes _____	No _____
Email?	Yes _____	No _____			

1. **Gender:** _____ 2. **Age:** _____ 3. **Date of Birth:** _____

4. **Race/Ethnic Background:** _____

5. **Cultural Considerations:** Yes ___ No ___

If yes, specify _____

6. **Learning Considerations:** Yes ___ No ___

If yes, specify _____

7. **Religion:** _____

8. **Sexual Orientation:** _____

9. **Relationship Status:** Single ___ Married ___ Divorced ___ Engaged ___ Dating ___ Living Together ___

Separated ___ Widowed ___ Self-Identify (please specify): _____

10. **Children:** Yes ___ No ___ How Many _____ Ages: _____

11. **Military:** Active ___ Reserves ___

12. **Branch:** Air Force ___ Army ___ Navy ___ Marines ___ USPHS ___ Coast Guard ___

13. **Veteran:** Yes ___ No ___

14. **Military Dependent:** Yes ___ No ___

15. **USU School/Year:** _____

16. **Are you Currently Employed?** Yes ___ No ___ **Average Number of Hours Per Week:** _____

17. **Who currently lives in your household?** _____

18. **Who Referred You To Counseling?** Self ___ Faculty ___ (Name: _____)

Staff ___ (Name: _____) Family Medicine Clinic ___ Friend ___

Other ___) _____

19. **Previous Counseling History:** Yes ___ No ___

If yes, specify year/length of time/reason:

20. **Previous Psychotropic Medication History:** Yes ___ No ___

If yes, specify year/length of time/efficacy/side effects:

21. **Family History of Mental Health Issues:** Yes ___ No ___

If yes, specify the relationship and diagnosis:

Please read this list and check the items of concern to you:

- | | |
|--|--|
| <input type="checkbox"/> 1. Adjustment to school | <input type="checkbox"/> 34. Failure or rejection |
| <input type="checkbox"/> 2. Academics/Grades | <input type="checkbox"/> 35. Difficulty making decisions |
| <input type="checkbox"/> 3. Learning disability/Attention Deficit Disorder | <input type="checkbox"/> 36. Unable to concentrate |
| <input type="checkbox"/> 4. Unsure of Career Choice | <input type="checkbox"/> 37. Sexual Matters |
| <input type="checkbox"/> 5. Financial Problems | <input type="checkbox"/> 38. Divorce adjustment |
| <input type="checkbox"/> 6. Too tired to do much of anything | <input type="checkbox"/> 39. Sexual Assault/Rape |
| <input type="checkbox"/> 7. Sleep problems/Nightmares | <input type="checkbox"/> 40. Confused about religious beliefs |
| <input type="checkbox"/> 8. Headaches | <input type="checkbox"/> 41. Being a nontraditional student |
| <input type="checkbox"/> 9. Loss of appetite | <input type="checkbox"/> 42. Uncertain about gender identity |
| <input type="checkbox"/> 10. Eating habits/problems | <input type="checkbox"/> 43. Uncertain about sexual identity |
| <input type="checkbox"/> 11. Sudden changes in my personality or behavior | <input type="checkbox"/> 44. Own use of Drugs/Alcohol |
| <input type="checkbox"/> 12. Isolating Self | <input type="checkbox"/> 45. Another's use of Drugs/Alcohol |
| <input type="checkbox"/> 13. Feel that others do not like me | <input type="checkbox"/> 46. STD/HIV/AIDS |
| <input type="checkbox"/> 14. Uncomfortable at social gatherings | <input type="checkbox"/> 47. Parental conflict |
| <input type="checkbox"/> 15. Trust Issues | <input type="checkbox"/> 48. Family Problems/Pressure |
| <input type="checkbox"/> 16. No close friends | <input type="checkbox"/> 49. Abuse: emotional ___ sexual ___ physical ___ |
| <input type="checkbox"/> 17. Relationship/Marital problems | <input type="checkbox"/> 50. Thoughts of suicide: within last 24 hours ___
within last week ___ within last 6 months ___ |
| <input type="checkbox"/> 18. Roommate problems | <input type="checkbox"/> 51. Have you had any serious illness or injuries in
your life? If yes, please list: _____
_____ |
| <input type="checkbox"/> 19. Whether or not to get/stay married | <input type="checkbox"/> 52. Have you tried to control your weight? If yes,
How? Dieting ___ Exercise ___
Vomiting ___ Laxatives ___ |
| <input type="checkbox"/> 20. Too easily influenced by other people | <input type="checkbox"/> 53. Has there been a death of anyone close to
you in the last five years? If yes, who?
_____ |
| <input type="checkbox"/> 21. Nervous/Worrying too much | <input type="checkbox"/> 54. How many times per week do you exercise?
One or less ___ Two to four ___ Five or more ___ |
| <input type="checkbox"/> 22. Anger | <input type="checkbox"/> 55. How many people can you really count on
right now, for emotional support?
_____ |
| <input type="checkbox"/> 23. Unhappiness | |
| <input type="checkbox"/> 24. Feeling guilty | |
| <input type="checkbox"/> 25. Grief/Loss | |
| <input type="checkbox"/> 26. Abortion | |
| <input type="checkbox"/> 27. Dissatisfaction/Loss of interest in things | |
| <input type="checkbox"/> 28. Lonely | |
| <input type="checkbox"/> 29. Difficulty expressing my emotions | |
| <input type="checkbox"/> 30. Feeling Depressed/Sadness | |
| <input type="checkbox"/> 31. Discouraged about my future | |
| <input type="checkbox"/> 32. Feeling inferior | |
| <input type="checkbox"/> 33. Afraid of making mistakes | |
| <input type="checkbox"/> 56. Do you have the desire or need to harm yourself through: | |
| <input type="checkbox"/> cutting | <input type="checkbox"/> burning |
| <input type="checkbox"/> severing | <input type="checkbox"/> inserting |
| <input type="checkbox"/> hitting | <input type="checkbox"/> constricting |
| <input type="checkbox"/> picking | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> 57. Has any member (s) of your family, other than you been diagnosed with a mental health concern | |

Please specify the relation

Overall, to what extent is your **academic performance** (concentration, memory, motivation, class attendance, assignment completion) being affected by the problem (s) you want to work on in counseling? Please circle a number on the rating scale.

1	2	3	4	5
No	Slight	Moderate	Much	Major
Effect	Effect	Effect	Effect	Effect

Please state, in your own words, what you would like to discuss with the counselor?

Is there anything else you would like your counselor to know about you?

Please read this list and check the behaviors that you have tried in order to cope with your concerns:

- | | |
|--|---|
| <input type="checkbox"/> 1. Talked with at least one family member | <input type="checkbox"/> 9. Changed physical appearance |
| <input type="checkbox"/> 2. Talked with at least one friend | <input type="checkbox"/> 10. Art/Music/Dance |
| <input type="checkbox"/> 3. Talked with partner/spouse | <input type="checkbox"/> 11. Keeping a journal |
| <input type="checkbox"/> 4. Talked with minister | <input type="checkbox"/> 12. Recreational activities/Hobbies |
| <input type="checkbox"/> 5. Prayer/Meditation | <input type="checkbox"/> 13. Read self-help books |
| <input type="checkbox"/> 6. Exercise | <input type="checkbox"/> 14. Worked extra hours/Studied more |
| <input type="checkbox"/> 7. Eating | <input type="checkbox"/> 15. Community service |
| <input type="checkbox"/> 8. Drugs/Alcohol | <input type="checkbox"/> 16. Avoid/Ignore the problems all together |

What are your goals for counseling (i.e., what do you want to occur as a result of counseling)? Please be as specific as possible.

1. _____
2. _____
3. _____