Jefferson Student Counseling Services

MISSION

The Mission of the Jefferson Student Counseling Services is to support the emotional and health and wellness of Jefferson students and well-being of the campus community through counseling, consultation, and outreach. Counselors strive to uphold strict confidentiality and the clinical and ethical standards of their professions. Counseling Services values, respects, and supports diversity and students of all backgrounds.

YOUR RIGHTS

ELIGIBILITY

All enrolled students with a current and valid Jefferson student with a current and valid Jefferson student ID are eligible to receive services.

SERVICES AVAILABLE

Counseling Services offer counseling, brief treatment interventions, crisis intervention, and referral services to Jefferson students. When clinically appropriate, Counseling Services offers group psychotherapy and psychiatric/psychopharmacological services. Counseling Services offers limited psychiatric services in the form of psychiatry consultation and short-term psychopharmacologic treatment to students who are active clients of Counseling Services. Your counselor could be a licensed clinician or a trainee under the supervision of a licensed clinician.

Counseling Services sees to balance the needs of individual students with the needs of the Jefferson population as a whole. During the initial appointment, you will meet with a counselor, which may include continuing therapy on campus or receiving a referral to an off-campus provider.

If it is determined that a student's needs fall outside of the Scope of Clinical Practice at any stage of treatment in the community that the counselor believes would best address the student's needs and circumstances. Counseling staff are also available to assist students at distant locations by providing mental health referrals and resources in the student's community.

You have the right to refuse diagnostic or treatment service at any time. Counseling Staff are available for in-person crisis evaluations during normal business hours. After hours, on-campus students experiencing an emergency should call Public Safety on the appropriate on campus. Off-campus students experiencing an emergency should call 911 or go to the nearest emergency room.

PRIVACY

Counselors strive to uphold strict confidentiality and the clinical and ethical standards of their professions. Because, Counseling Services operates as a team approach, Counseling Services operates as a team approach, Counseling Services staff on the Center City and East Falls campuses may confer with each other as professionally necessary to provide you the best possible service. It is important that you review Jefferson's Notice of Privacy Practices.

LIMITS TO CONFIDENTIALITY

There are certain exceptions to confidentiality permitted by law including situations where there is a threat or danger to life, including situations of child or elder abuse; if you are a minor (under the age of 18); or through subpoena or court order.

YOUR RESPONSIBILITIES

PARTICIPATION

Your active participation in the counseling process is necessary for progress to be made. It is important that you notify your counselor if your problem worsens. It should be noted that if you arrive to Counseling Services under the influence, you will be asked to reschedule your appointment.

CANCELLATIONS

It is your responsibility to keep scheduled appointments. If you need to reschedule or cancel, please give us at least 24-hours' notice so that the time may be offered to another student in need. If you are persistently unable to keep your schedule appointments, your counselor may discuss alternative treatment options for you.

FEEDBACK

Counseling Service Staff is interested in any positive or negative feedback you may have regarding the services you receive. We may ask you to complete an anonymous evaluation asking you for feedback about our services. If your concerns are not resolved to your satisfaction, you may be request a meeting with the Counseling Services Director to discuss other counseling options.

CONSENT TO TREATMENT

I hereby agree to counseling/treatment/assessment/consultation at the Student Counseling Center. I have read the information contained above and understand these provisions and policies. I understand I may address any questions regarding this consent with a counselor. I also understand that this consent will remain in effect until I am no longer a Jefferson student, and that I have the right to later revoke my consent. If I do not sign this consent, or later revoke it, the Student Counseling Center may decline to provide services to me.

SIGNATURE: ______________________________ DATE: ____________________

Patient Registration Form

Today's Date:

Please complete this form in order to ensure proper billing of your services. **Please Print.**

Patient's Last Name	Patient's First Name	MI

DOB / /	Sex ☐ M ☐ F	Social Security Number – –	Language ☐ English ☐ Other ______

Race ☐ African American or Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Caucasian or White ☐ Unknown ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not-Hispanic or Non-Latino ☐ Unknown ☐ Declined

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other ______

Address Line 1	Address Line 2	
City	State	Zip
Home Phone	Preferred Phone	Cell Phone
Home E-mail		

Emp Status ☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Active Military ☐ Homemaker ☐ Student Full Time ☐ Student Part Time ☐ Other ______

Employer	Work Phone	
Employer's Address Line 1	Employer's Address Line 2	
City	State	Zip

Please complete if guarantor is other than self. *(Guarantor is the person financially responsible for this patient's bill.)*

Guarantor's Last Name	Guarantor's First Name	MI

DOB / /	Sex ☐ M ☐ F	Social Security Number – –	Patient's Relationship to the Guarantor	Guarantor's Home Phone

Guarantor's Address Line 1	Guarantor's Address Line 2	Guarantor's Work Phone
City	State	Zip
Guarantor's Employer		
Guarantor Employer's Address Line 1	Guarantor Employer's Address Line 2	
City	State	Zip

Emergency Contact Information

Emergency Contact's Last Name	Emergency Contact's First Name	MI
Patient's Relationship to the Emergency Contact	Primary Phone	Secondary Phone

Please select the source in which you heard of our practice

☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ JEFF NOW® ☐ Mass Mailing ☐ Newspaper/Mag. ☐ Ongoing Care
☐ Patient ☐ Phone Book ☐ Phys. Off./ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other ______

Insurance Information *A separate form is required for workers' compensation, automobile liability, or legal services.*

Primary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#	Subscriber's Employer		
Secondary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#	Subscriber's Employer		

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ______ Somewhat difficult ______ Very difficult ______ Extremely difficult ______

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AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol)

=

8-9 oz. of malt liquor (about 7% alcohol)

=

5 oz. of wine (about 12% alcohol)

=

1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at *www.who.org*.

Jefferson Student Counseling Services
Client Consent for Electronic Mail ("Email") Use

EMAIL	This consent from provides information on the appropriate usage of email between Counseling Services and its clients.
DO NOT USE EMAIL	Clients should never use email in CASES OF A MEDICAL EMERGENCY OR FOR URGENT OR TIME SENSITIVE MATTERS. Please avoid email for communicating sensitive health care information such as sexually transmitted diseases, HIV, hepatitis, substance abuse, mental health or the presence of malignancy. Do not send any attachments by email. Do not use email to request copies of medical records. Do not use an employer's computer to send emails. Employers have a right to archive and inspect emails transmitted through their systems. Do not use email as a substitute for clinical evaluations and office appointments.
PRIVACY, SECURITY & CONFIDENTIALITY	Although the University has implemented reasonable technical safeguards, we cannot and do not guarantee the privacy, security or confidentiality of any email messages sent or received over the internet can be intercepted, altered, forwarded, and/or read by others. The University, including Counseling Services, is not responsible for email messages that are lost due to technical failure during composition, transmission, or storage. We will not forward emails to independent third parties without a patient's prior written consent, except as authorized or required by law. Clients must inform Counseling Services of email address changes. Clients should take precautions to preserve the confidentiality of email, such as safeguarding computer passwords.
CREATING A MESSAGE	In the "Subject" line of the email, clients should include the general topic of their message (i.e. medical advice). In the "Body" of the email message, please include client's name and date of birth. This information is necessary to verify client identity and make sure Counseling Services can include the email in the correct medical record.
EMAIL RESPONSE	Counseling Services cannot guarantee that you will receive a response to any particular email. If you have not received a response within a reasonable time period, please call your provider.
EMAIL USE BY COUNSELING	You understand that if you give your email address and sign this consent form, you are allowing Counseling Services to communicate with you via email.
ENDING EMAIL	You may revoke your consent to communicate by email by sending a written communication, such as an email or letter, to Counseling Services.

ACKNOWLEDGMENT: I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of email as one form of communication with Counseling Services.

NAME: ______________________________ DATE: ________________

Patient Name: ______________________ Date of Birth: ______________
(Please Print)

IDX Account #: ______________________

Acknowledgement of Receipt of Notice of Privacy Practices and Authorization to Release Health Information

By signing below, I acknowledge receipt of the Notice of Privacy Practices of Thomas Jefferson University ("TJU"), Jefferson University Physicians ("JUP"), and TJUH System and its controlled affiliates including Thomas Jefferson University Hospitals, Inc. ("TJUH") (collectively referred to as "Jefferson"). In addition, by signing below, I authorize Jefferson to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature: ______________________ Date: ______________

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the reasons why the acknowledgement was not obtained:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please specify): ______________________

______________________ ______________
Signature of Jefferson Representative Date