SUMMARY OF CLIENT RIGHTS AND RESPONSIBILITIES

Welcome to Clinical Counseling Services (CCS). So that we may better serve you, we request that you read the following information and sign where indicated. Our mission is to provide psychological services, training opportunities, proactive mental health programs and co-curricular activities that promote student development and, thereby, support and enhance the missions of the Division of Student Affairs and Lawrence Technological University.

Your rights as a recipient of counseling services:

• **Right to Confidentiality:** Communication between the student and the staff of CCS is confidential and will not be disclosed without your written consent.

  The law of the State of Michigan provides the following exceptions, (a) if the therapist has knowledge of a child, an elderly person, or a disabled person being abused or neglected, (b) if the therapist has knowledge of a client’s intent to harm himself/herself or others, (c) if the therapist receives a court order to the contrary, and (d) if the therapist or student in training is supervised or consults with another clinical psychologist or mental health therapist.

• **Right to Consent:** You have the right to be informed about the nature of CCS services. If you do not agree with some part of the services you are receiving, you have the right to withdraw your consent to receiving services at any time.

• **Right to be Treated with Dignity:** You have the right to be treated with respect for your personal dignity, autonomy and privacy. CCS staff are required to protect and promote the basic human dignity to which you are entitled.

• **Discrimination Rights:** It is the policy of CCS that no client will be discriminated against on the basis of race, ethnicity, national origin or ancestry, age, gender, religion, sexual orientation, disability or socioeconomic status.
Your responsibilities as a recipient of counseling services:

- You are expected to come to appointments and activities on time, inform CCS staff of any changes in your phone number or address, and call CCS-at least 24 hours in advance-when you cannot keep an appointment.

- If you do not show up for or cancel two appointments consecutively, you must contact your therapist, via telephone or email, about the circumstances of your situation before being able to schedule another appointment. Your therapist is responsible for deciding whether or not you may schedule another appointment.

- You are expected to inform your therapist if and when you plan to discontinue treatment/services.

- You are expected to respect the care and treatment of other students. This means respecting the rights of others just as you expect them to respect your rights.

Note regarding email: In order for CCS staff to communicate with you via email regarding appointments, you must check and initial the box on the consent form. When emailing CCS, we ask that you be mindful that email is not a confidential form of communication. We cannot guarantee confidentiality when using email. To ensure confidentiality and protect your privacy, clinical services cannot be provided via email. These services may include individual counseling, psychological testing, consultation, and group services.

I have read the Summary of Client Rights and Responsibilities and know that, at any time, I can seek additional information about them from my therapist.

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Please take a copy of this form with you and refer to it as needed throughout your counseling experience.

rev.4.9.14
COUNSELING INTAKE FORM

(Please Print)

Last Name __________________________ First Name ______________________ Middle Initial _____

Today’s Date _______________________ Banner ID Number __________________________

Current Living Situation

☐ Dorm   ☐ Check One: ☐ Donley Hall  ☐ South Hall  ☐ Reuss Hall  ☐ East Hall  ☐ Arbor Lofts
☐ House   ☐ Apartment   ☐ Other

Address ________________________________________________________________

________________________________________________________________________

With whom do you live? __________________________________________________

Cell Phone Number __________________________ Email _________________________ @ltu.edu

Home/School Phone Number ________________________________________________

Gender ____________________ Age ____________________ Grade Level________________

Relationship Status  ☐ Single  ☐ Dating  ☐ Married  ☐ Separated  ☐ Divorced  ☐ Other

Major __________________________ GPA ________ Current Number of Credits ______

Referred By ______________________________________________________________

Who should be contacted in case of emergencies?

________________________________________________________________________

(Name) __________________________ (Relationship) __________________________ (Phone #) _______

Are you an international student?  ☐ Yes   ☐ No

If yes, what is your country of origin? _______________________________________

What brings you to the Counseling Office at this time? _________________________

________________________________________________________________________

*****PLEASE TURN THE PAGE OVER*****

Lawrence Technological University | Clinical Counseling Services
21000 West Ten Mile Road, Southfield, MI 48075-1058 | 248.204.4100 p | 248.204.4115 f | clinicalcounseling@ltu.edu | ltu.edu
Revised 2.7.2020
What outcome would you like from our service?  ___________________________________________

____________________________________________________________________________________

Have you seen a counselor/social worker/psychologist before? □ Yes □ No

If yes, please list provider and Dates:

Provider ___________________________ Dates From ______________ to ______________

Notes: ____________________________________________________________________________

____________________________________________________________________________________

Have you ever been hospitalized? □ Yes □ No  If yes, please describe ______________________

____________________________________________________________________________________

Have you had suicidal ideation or suicide attempts? □ Yes □ No  If yes, please describe ______

____________________________________________________________________________________

Do you have any medical conditions? □ Yes □ No  If yes, please describe ______________________

____________________________________________________________________________________

____________________________________________________________________________________

Are you taking any medications at this time? □ Yes □ No  If yes, please list name(s) of medication,
dosage and how often taken __________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Alcohol use in the past 6 months _________________________________________________________

____________________________________________________________________________________

Substance use (ex. marijuana) in the past 6 months _________________________________________

____________________________________________________________________________________

Is there anything else you would like us to know? ________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
CONSENT TO TREATMENT

I hereby give my consent to receive counseling services. These services may include psychological evaluations, treatments and referrals. I understand that information regarding my case may be shared among Clinical Counseling Services (CCS) staff for supervision, consultation and training purposes only. However, all information pertaining to my case will be considered strictly confidential and will not be released to anyone outside of CCS without my specific written consent as stated below.

I have read and signed the “Summary of Client Rights and Responsibilities.” I have been informed and understand confidentiality, the limits of confidentiality, and my rights and responsibilities as a client.

________________________________________  __________________________
Student Signature  Date

_____ I give consent for my therapist to respond to my inquires via email. _____

Initials

_____ I give consent for my therapist to discuss my case with the following:

________________________________________________________________________

Clinical Counseling Services (CCS) is operated and funded by Lawrence Technological University primarily for the benefit of registered students. CCS offers a variety of services including individual and group counseling/therapy, crisis intervention, psychological evaluations, consultations, outreach programs and referral services. The services are provided by the clinical staff and supervised graduate students.

rev.4.9.14