



**SOUTHERN METHODIST UNIVERSITY HEALTH CENTER  
COUNSELING AND PSYCHIATRIC SERVICES  
CONSENT FOR COUNSELING AND TREATMENT**

**Consent to Treatment**

By signing my name below, I hereby represent that I am voluntarily consenting to mental health care provided by the psychiatrists, psychologists, employees, and other health care providers (hereinafter referred to collectively as “Mental Health Professionals”) available through the Counseling and Psychiatric Services (“CAPS”) of the SMU Student Health Center. I understand that CAPS may share my psychiatric records with SMU’s Health Center physicians if beneficial for continuation of care. I acknowledge that SMU cannot warrant or guarantee the result or cure by any of its Mental Health Professionals. I understand and acknowledge that this consent to treatment is valid and remains in effect for as long as treatment at CAPS occurs, unless I provide a written revocation of this consent to the SMU CAPS. I understand that I may revoke this consent and terminate treatment at any time. I understand that to be eligible for evaluation and treatment at the CAPS, I must be a currently registered student at SMU.

**Explanation of Confidentiality and Consent for Disclosure of Clinical Records:**

I understand that as a general rule the information I share with a SMU Mental Health Professional is confidential and may not be disclosed to others without my prior written consent.

**Initial Here**

\_\_\_\_\_ **I understand that there are exceptions to confidentiality, and I further consent to release of information from my records in the following circumstances:**

1. Information released to other professionals involved in treatment. Most commonly, this would be to other members of SMU CAPS (if involved in your treatment), or a SMU Health Center physician (if assisting in managing your treatment).
2. If you are under 18 years of age, your parents or legal guardian(s) may request access to your records and may authorize their release to other parties.
3. If you are determined to be in imminent danger of harming yourself or someone else.
4. If you are assessed as being unable to care for yourself.
5. If you disclose abuse or neglect of children, the elderly, or disabled persons.
6. If you report that you have been sexually abused by a previous mental health professional, your current mental health professional has a legal duty to report the abuse to the proper authorities. Such a report need not include your name if you wish it not to be given.
7. If SMU receives a court order for your mental health records.
8. To qualified personnel for certain kinds of program audits or evaluations.

**NOTE: Students should be aware that many states, including Texas, ask about mental health diagnoses and treatment as part of application to the bar to practice law. In a few states, medical boards request this information as well. Similar information is requested by some religious denominations prior to ordination. Some federal agencies require releasing this information for applicants for sensitive government positions. In the past, we have responded to these requests with brief summaries, which have been sufficient. This information is only released with your written consent.**

I understand that as part of the provision of health care and counseling services, SMU’s Counseling and Psychiatric Services creates and maintains clinical records and other information describing among other things, my mental health history, my medical history, symptoms, assessment and test results, diagnoses, if applicable, treatment, and any plans for my future care or treatment. I understand that I have a right to access and review my clinical record unless deemed harmful to my mental health by my mental health professional. I understand I can make that request in writing at any time.

I am aware that my appointments, personal demographic data, and clinical records are kept on CAPS password-protected computers, and any reports on Center computers are password protected. I am aware that this information is maintained in an electronic format that is also used by the SMU Health Center, and the following counseling information is available to Health Center medical staff: date of last visit, counselor name, and diagnoses.

Group statistics, if shared with others and possibly published, will be done in such a way to preserve my anonymity. Further, I am aware that a file on me is maintained for 10 years or, if I am a minor, for 10 years after I turn 18 years old. I understand that my former files from the CAPS, if any, will be combined to form my current CAPS record.

**COUPLE'S COUNSELING:** In order to be eligible for couple's counseling, my partner or I must be a currently registered student at SMU. Mental health records related to couple's counseling sessions are maintained in a couple's record. I understand that the same confidential status to the record as described above, including exceptions to confidentiality, applies to couple's counseling records. I also understand and accept that the actual contents of the couple's record will not be released to myself or others without prior written consent from both my partner and myself.

**GROUP COUNSELING:** Records related to group counseling sessions are maintained in a student's individual record with the identifying information for other group members removed. Although the information discussed in group sessions is considered confidential by SMU CAPS staff members, confidentiality by other group members cannot be guaranteed. Confidentiality will be discussed and strongly encouraged among all group members as a vital part of group membership.

## **Commitment to Treatment**

I am aware that SMU CAPS offers brief psychotherapy (typically up to 16 sessions) and psychiatric services for registered SMU students. I additionally understand that the mental health professionals at CAPS agree to evaluate my mental health concerns to determine where my needs can best be met. When appropriate, they will furnish me with names of resources within the community.

I understand that CAPS services are available from 8:30 a.m. to 5:00 p.m. Monday through Friday except during university holidays, fall/spring breaks, or between fall and spring semesters. For urgent matters, I know to call 214-768-CAPS (2277) follow instructions to call the clinician on call. If I do not receive a call back promptly, I should call the SMU Police at 214-768-3333 and the clinician will be notified without you having to reveal any personal information. If it is a life threatening situation, I know to go to the nearest emergency room. In the event of a sexual assault, call 214-657-6967 at any time or day.

### **Initial Here**

\_\_\_\_\_ **I agree to make a commitment to the treatment process, including the following:**

- Consistently attending sessions (or letting CAPS know when I cannot attend)
- Voicing my opinions, thoughts and feelings (positive and/or negative)
- Being actively involved during sessions
- Experimenting with new ways of doing things
- Taking medication (if prescribed) as prescribed

I understand that my SMU Mental Health Professional I and I will work together to define treatment goals and procedures. I also realize that sometimes during the course of treatment distressing memories, feelings, and thoughts are aroused and that insights gained may produce changes that may affect or even end established relationships.

**Attendance Policy**

**In fairness to students wanting to secure timely services from CAPS, students who miss an appointment without notifying the Center at least 24 hours prior to the appointment time may have a \$20.00 No-Show fee charged to their SMU account.**

Since demand for services is typically high, we ask that you only schedule appointments that you are confident you will keep. If you are unable to keep an appointment, please call the CAPS office to cancel the appointment, making every effort to give at least 24 hours' notice so that we may make the time slot available to another client.

**Initial Here**

\_\_\_\_\_ I understand that if I fail to give at least 24-hours-notice of a missed appointment, my student account may be charged \$20.00

\_\_\_\_\_ I also understand that after two No-Show appointments, all future appointments may be cancelled, and I may be referred to the community for services.

\_\_\_\_\_ I understand that e-mail, voicemail and letter mail are not confidential means of communication. By signing this consent, I authorize CAPS to use the designated means I endorsed on the Client Information Form on file to contact me by e-mail, voicemail or letter mail only for appointments and/or scheduling and only when necessary and I agree to keep this information updated.

\_\_\_\_\_ I understand that e-mail of CAPS staff members is not checked daily (or on evenings or weekends), and that I need to call for all routine and particularly urgent matters.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Legal Name

\_\_\_\_\_

\_\_\_\_\_  
Parent's Signature (if client is under 18 years of age)

\_\_\_\_\_  
Date

*I wish to rescind this consent effective \_\_\_\_\_ (date).*

\_\_\_\_\_  
*Client's Signature*

\_\_\_\_\_  
*Date*