

**MEDICAL AND COUNSELING CONSENT FOR
TREATMENT: UNEMANCIPATED MINOR**

Patient Name: _____ **Birthdate:** ____ / ____ / ____
University ID: _____

1. **Authority.** I am the parent, guardian or other person legally authorized by Idaho law to consent for health care services for the Minor Patient pursuant to Idaho Code § 32-1015.
2. **Consent for Treatment.** I voluntarily consent to and authorize Health Services (HS) and its employed or affiliated physicians, practitioners, and staff (collectively “Providers”) to render the following health care services to the Minor Patient:

General Consent. Medical evaluation, diagnosis and treatment; diagnostic services including lab tests or radiology procedures; prescription and administration of medications; counseling; and any other health care services as defined in I.C. § 32-1015 deemed reasonably necessary and appropriate by the treating Provider. This consent shall constitute a “blanket consent” within the meaning of I.C. § 32-1015(4)(a) and no further consent is required to authorize such health care services.

or

Consent for Specific Care [Describe]. _____

3. **Information.** The Provider has explained the nature of the proposed health care services, alternatives, and their related risks and benefits, or I have waived my right to receive such information. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction or I have declined to ask such questions. If I require additional information concerning the health care services, I will contact Health Services (HS) or the Provider to discuss such services. I understand that the practice of medicine is not an exact science and no promises or guarantees have been made nor can they be made to me concerning the outcome of the health care services.

I understand that if I am not present in cases of emergency and/or when treating major medical illnesses or injuries, Health Services (HS) will attempt to obtain my consent via telephone. I also understand that in such cases where Health Services (HS) has been unable to contact me, and in the provider’s opinion a delay in initiation or provision of treatment would endanger the health or physical well-being of my son/daughter, Health Services (HS) will render the necessary emergency medical care to my son/daughter without my consent.

4. **Financial Responsibility.** I agree that I am ultimately responsible for payment for the health care services rendered to the Minor Patient and agree to comply with Health Services (HS) Financial Policies. I will promptly pay any co-payments, deductibles, or other amounts not covered by applicable insurance or third-party payor program. I will cooperate with Health Services (HS) in obtaining reimbursement for the health care services from any third-party payor, and hereby assign to Health Services (HS) the right to submit claims for payment to third-party payers and retain such payments. To the extent allowed by law, I will remain responsible for any amount not paid by any third-party payor for health care services, including but not limited to costs relating to infectious, contagious or communicable diseases within the meaning of I.C. § 39-3801. If the Minor Patient’s account becomes delinquent, I agree to pay interest and fees according to GROUP’s Financial Policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys’ fees, and court costs.
5. **Counseling Services/Mental Health Provider Credentials.** All of the providers at Health Services Counseling Services are qualified professionals. The senior staff consists of psychologists, counselors and social workers at the master or doctoral levels with the appropriate credentials and/or licensure. Our staff also includes trainees; this may include Counseling Graduate Trainees and Social Work Trainees, who are working toward completion of their graduate degree. All of the trainee staff are supervised closely by a Counseling Services senior staff Provider.
6. **Client Rights.** The providers are required to adhere to the professional code of ethics adopted by the state profession board. You have the right to file a complaint without retaliation in writing to the Idaho Division of Occupational and Professional Licenses located at 11341 W. Chinden Blvd. Building 4, Boise, ID 83714, or by phone at 208-334-3233. IBOL Rule 525 for counselors stipulates that you be informed that the relationship between client and counselor will always be of a professional nature only and that any sexual or inappropriate behavior will not be permitted at any time, and should be reported to the board.
7. **Benefits and Risks of Counseling and Assessment:** Benefits of counseling may include but are not limited to: an improved ability to relate to others; a clearer understanding of self, values and/or goals; increased academic productivity; and an ability to cope with everyday stress.



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While benefits are expected from the counseling process, there may be periods of increased anxiety or uncertainty, which may affect relationships, jobs, and/or understanding of oneself. It is impossible to predict the extent to which one might experience these changes. Your son/daughter and their provider will work together to maximize the benefits of the counseling process.

Benefits of assessment may include but not be limited to: a clearer understanding of self, values and/or goals, increased academic productivity a clearer understanding of strengths, limitations and strategies to maximize potential. Although benefits are expected from the assessment process, it is impossible to predict the outcome of the assessment. It is possible that a client will not receive the diagnosis they are seeking, or may receive a diagnosis they are not expecting. It is also possible that we will not be able to offer a specific diagnosis or answer any problem(s) through the assessment process. Your son/daughter and their provider will work together to maximize the benefits of this process. Participation and payment for an assessment does not guarantee any results.

8. **Confidentiality.** In compliance with applicable Federal Laws and regulations along with Idaho state statutes, all the information obtained during counseling sessions will be kept confidential as required by law. Information gathered during a counseling session will not be revealed to anyone outside of Health Services without proper consent except in the following situations where disclosure is required by law:

- Where there is reasonable suspicion or report of abuse to vulnerable populations, including children, elderly persons, and individuals who are unable to advocate for themselves.
- Where one presents serious and foreseeable harm to oneself or others.
- If we receive a subpoena, court order, or as part of legal proceedings which may include but is not limited to legal complaints filed by you or your son/daughter against their provider.
- In specific cases of law enforcement emergency for national security issues.

In rare circumstances where the University receives report of concerning behavior that could put ones welfare or the safety of others at risk, University Health Services may disclose to the C.A.R.E. Team information about your son/daughters appointment-attendance history; no other information about counseling sessions will be disclosed.

9. **Assent for Minors.** As a general rule, your son/daughter’s provider will not talk to you as their parents/guardians about what is discussed in counseling without their knowledge. If their provider believes there is something that you, as parents/guardians need to know, s/he will encourage them to tell you and together they can address ways for them to do so. There may be circumstances where they choose not to tell you alone, in which case, their provider will then assist them in a conjoint session with you to discuss needed information.

Their provider will not share their information outside of Health Services (HS) without their knowledge. It is unlikely, but possible, that a situation may arise in which you and their provider both believe it is important for to share information with someone, and they do not agree. In this case, their Provider will use his/her professional judgment on whether to share information.

I have read, understand, and agree to the foregoing, and I understand and acknowledge that Health Services (HS) and/or its Providers will render health care services in reliance on this consent.

Name

Date: ____ / ____ / ____

Phone Number

Relationship to Minor Patient

FOR COUNSELING PROVIDERS ONLY

Counseling Services Provider: _____ (Printed)

Signature: _____ Date: _____





BOISE STATE UNIVERSITY

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Personal and Health Information

Boise State University Health Services (“Health Services”) is required by applicable federal and state laws to maintain the privacy of your protected health information, and to notify affected individuals following a breach of unsecure health information. This notice explains our privacy practices, our legal duties, and your rights concerning your health information. Our duties and your rights are set forth more fully in 45 CFR Part 164. While this policy is in effect, we are required by law to abide by its terms.

Uses and Disclosures We May Make Without Written Authorization

For certain purposes Health Services may use and or disclose your health information without your written authorization. These include the following circumstances:

- **Treatment:** We may use and disclose your health information to provide treatment to you, or for continuation of treatment activities.
For Example: We may share your information with another healthcare provider so they may treat you.
- **Payment:** We may use and disclose your health information to obtain payment for services provided to you.
For Example: We may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.
- **Health Care Operations:** We may use and disclose your health information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care.
For Example: We may use information to train or review the performance of our staff or make decisions affecting the practice. We may also call you by name in the waiting room when Health Services staff is ready to see you.

Other Uses and Disclosures

Health Services may also use or disclose your information for certain other purposes as allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid serious threat to your health or safety or the health and safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- For certain public health activities, such as reporting certain diseases.
- For certain public health oversight activities, such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.

Effective date of this notice: July 1, 2023



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- For certain specialized government functions, such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement, such as to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.
- Scheduling and appointment reminders
- Plan Sponsors: If you are enrolled in the Graduate Assistant or International Student Health Insurance plans, we may disclose your health information to the sponsor to permit it to perform administrative activities.
- Underwriting: We may receive, use and disclose your health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of the contract for SHIP.
- If you are a minor: Some state laws concerning minors permit or require disclosure of protected health information to parents, guardian, and persons acting in a similar legal status. We will act consistently with the laws of Idaho and will make disclosures consistent with such laws.
- To your family and/or friends in the event of an emergency.

Disclosures We May Make Unless You Object:

Unless you notify us otherwise in writing, we may disclose your information as described below:

- For marketing purposes: Such as to inform you of health related products and services or about treatment alternatives that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you with the choice to opt out of those activities. You may also choose to opt back in.
- To maintain a facility directory: If a person were to ask for you by name, we will only disclose if you were seen at Health Services.

Uses and Disclosures with Your Written Authorization:

Other uses and disclosures not described in this Notice will be made only with your written authorization, including most disclosures of psychotherapy notes (if the provider you saw kept psychotherapy notes), most marketing purposes, or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance of the authorization.

Your Patient Rights Concerning Your Protected Health Information:

You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the HIPAA Privacy Compliance Officer.

- You may inspect and obtain a copy of your records that are used to make decisions about your care, or payment for your care. We may deny your request under certain circumstances. For example: if we determine that disclosure may result in harm to you or others.

Effective date of this notice: July 1, 2023

1910 University Drive Boise, Idaho 83725-1351
Phone (208) 426-1459 Fax (208) 426-3005



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- You may request that your protected health information be amended. We may deny your request for certain reasons such as: if we did not create the record or if we determine that the record is accurate and complete.
- You may request an accounting of disclosures we have made of your protected health information.
- You may request additional restrictions on the use or disclosure of information for treatment, payment or health care operations. However, we are not required to agree to the restrictions except in the limited situation in which you, or someone on your behalf pays for an item or service in full, and you request that the information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, text message, email, or at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You have the right to obtain a paper copy of this Notice upon your request. You have this right even if you have agreed to receive the Notice electronically.
- You have the right to receive notice of a breach. We will notify you if your unsecured protected health information has been breached.

Communication through Email

We ask you not to use your personal email in contacting our staff. Emails sent to and from your personal email address are not secure and could be intercepted by a third party. We strongly encourage you to sign up for a patient portal account where you can read and respond to emails you receive from us, check your lab results, see your appointment summaries and check on your past and upcoming appointments. If you should have further questions we ask that you call our office directly so we can assist with answering your questions and taking care of your needs.

Changes to this Notice of Privacy Practices

Boise State University Health Services reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. If we materially change our privacy practices, we will post a copy of the current Notice on our website and all other locations which this Notice is posted. Until such time, Boise State University Health Services is required by law to comply with the current version of this Notice.

Complaints

If you have any questions regarding this Notice or if you feel any of your rights listed in this Notice have been violated you may file a complaint with the Secretary of Health and Human Services or by notifying our HIPAA Privacy Compliance Officer. All complaints must be in writing. We will not retaliate against you for filing any complaints.

Boise State University Health Services
Attn: HIPAA Privacy Compliance Officer
1910 University Drive
Boise, ID 83725-1351
Phone (208) 426-1459
Fax (208) 426-4059

Office for Civil Rights, Region X-Seattle
U.S. Department of Health and Human Services
Sharon D. Turner, Acting Regional Manager
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831
Phone: (206) 615-2010
Fax: (206) 615-2087

Signature: _____ Date: _____ University ID: _____

Effective date of this notice: July 1, 2023



HEALTH SERVICES PATIENT/CLIENT AGREEMENT

Thank you for choosing Boise State University Health Services as your health care provider. We are committed to providing you with quality health care.

Hours of Operation: Health Services is open from 8:00am to 5:00pm on Monday, Tuesday, Thursday, Friday, and from 10:00am to 5:00pm on Wednesday. Crisis counseling and urgent care medical services are available during the hours of operation; **no appointment is required.** Crisis counseling and urgent care medical services are meant for situations which cannot wait for a scheduled appointment.

Consent for Treatment: I authorize the staff of Boise State University Health Services, their employees, and consultants to undertake such treatment, diagnostic procedures, and medical procedures, which in their judgment may become necessary while receiving care at Health Services. I understand that I will be involved and engaged in my care and treatment; and that I have a right to a full explanation of any treatment or procedures utilized. I am aware the practice of medicine is not an exact science and I understand no guarantees have been made to me regarding the results of treatment or examinations. As a patient/client of Health Services, I understand that individuals being trained for a health care profession may participate in providing me care. I understand that if I require specialized care, emergency care, or care which is out of the scope of services for Health Services I will be referred to the appropriate facility and/or providers. I understand that an emergency contact will be notified of my condition if considered necessary by the professional staff at Health Services.

Confidentiality and Notice of Privacy Practices Acknowledgement: Medical and mental health information contained in all health records is confidential and may not be released without express written permission from the patient/client unless certain conditions are met.

- Where there is reasonable suspicion or report of abuse to vulnerable populations, including children, elderly persons, and individuals who are unable to advocate for themselves.
- Where you present serious and foreseeable harm to yourself or others.
- If we receive a subpoena, court order, or as part of legal proceedings which may include but is not limited to legal complaints filed by you against your provider.
- In specific cases of law enforcement emergency for national security issues.

In rare circumstances where the University receives report of concerning behavior that could put your welfare or the safety of others at risk, Health Services may disclose to the C.A.R.E. Team information about your appointment-attendance history; no other information about your care or treatment will be disclosed.

I understand that Health Services may release my health records (with the exception of psychotherapy notes) for treatment, payment, or health care operations, and for certain other purposes under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable federal or state laws and regulation. I also understand that I have certain rights to privacy in regard to my protected health information (PHI). I understand a copy of the Notice of Privacy Practices (Notice) which provides a comprehensive description of how my health information may be used and/or disclosed is available to me at my first appointment and upon request. I understand that I have the right to review the Notice prior to signing this acknowledgement form. I understand that Health Services reserves the right to change their notice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Health Services may not be required to agree with the restrictions I have requested.

Notice of Nondiscrimination and Accessibility: Boise State University Health Services (“Health Services”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats
 - Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please let us know upon scheduling your appointment.

If you believe that Health Services has failed to provide these services or discriminated against you or others in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: (Name and Title of Civil Rights Coordinator, mailing address, phone number, fax, email). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, (Name and Title of Civil Rights Coordinator) is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1(800)368-1019, (800)537-7697 (TDD)



BOISE STATE UNIVERSITY
HEALTH SERVICES

REGARDLESS OF STUDENT STATUS

PLEASE INITIAL FOR EACH BOX

Patient Financial Agreement and Acknowledgement of Office Policies: This agreement between Health Services and you, the patient, or the responsible party is provided to inform you of our financial policies. A complete version of this agreement is available upon request.

FEES: I understand that Health Services is a fee-for-service clinic and bills for its services. I understand that there may be additional 3rd party fees from outside facilities such as a lab, pharmacy, or other community providers, which are separate from Health Services.

INSURANCE: Health Services will attempt to bill your insurance. However, it is your responsibility to understand your insurance benefits and coverage, so please check with your insurance before receiving services. Health Services does not bill or accept Medicare, VA, or out-of-state Medicaid.

PAYMENT: For currently enrolled students, any balance after insurance will be transferred to your student account. Employees and non-enrolled students are expected to pay their copay and any other service we cannot bill to insurance on the date of service. All patients are to pay for medications at the time of service.

SELF PAY: You may decide to self-pay if you choose not to use your insurance, or if you are provided services for which we cannot/do not bill insurance, such as, but not limited to:

- a) massage therapy
b) dispensary medications
c) dietitian services
d) flat fee physicals

Proof of Insurance: You will be asked to show a copy of your insurance card when you check-in. If you are unable to show your current insurance card, we allow 24 hours after the date-of-service for you to provide your insurance information to us.

Missed/Late Appointments: Please help us serve you better by keeping scheduled appointments and giving 24 hours' notice on any cancellations.

I understand that I will be charged a \$40 no-show fee for any missed appointments with Health Services.

I understand that I will be charged a \$20 late cancellation fee for any appointment canceled within 24 hours of my scheduled appointment.

I understand that if I arrive more than 10 minutes late for a scheduled appointment, I will be rescheduled for that appointment.

Thank you for reviewing our Patient/Client Agreement. Please let us know if you have questions or concerns regarding this information. By signing below, you agree to the information stated above.

Emergency Contact Name

Relationship

Phone number

Printed Patient/Client Name

Date

Preferred Name

Pronouns

Patient/Client Signature

University ID Number



BOISE STATE UNIVERSITY
HEALTH SERVICES

RIGHTS AND RESPONSIBILITIES

Boise State University Health Services is committed to supporting and protecting the rights of each of our patient/clients. With these rights also come patient/client responsibilities. Active participation in your health care will assure the best outcomes.

PATIENT/CLIENT RIGHTS:

- To accept or refuse any care or treatment and understand the implication of refusal
- To receive fair and equal treatment in all circumstances regardless of your age, race, gender, sexual orientation, or religion
- To be treated with respect, consideration, and dignity
- To receive care in a safe environment
- To privacy of care
- To be informed of your provider's training status, including the limitations and restrictions of services
- To participate in decisions about your care and treatment
- To receive accurate, easily understood information about your health care concerns and the care you are receiving
- To be informed of the purpose, goals, techniques, procedures, limitations, potential risks, and benefits to treatment
- To ask questions about techniques and strategies used
- To work with your provider on a treatment plan you are comfortable with and will adhere to
- To receive education and counseling
- To request to transfer to another provider, when appropriate
- To confidentiality of your records
- To access your medical records
- To have your concerns heard and reviewed in an objective and timely manner
- To receive a copy of this consent form
- To file a complaint without retaliation

PATIENT/CLIENT RESPONSIBILITIES:

- To provide accurate information regarding your health history
- To be active in making decisions regarding your care
- To ask questions to seek clarification if you do not understand your treatment plan
- To follow the treatment plan prescribed by your health care provider
- To show courtesy and respect to health care personnel and other patient/clients
- To keep your appointments and arrive on-time
- To cancel or reschedule as far in advance as possible so that the time may be used to treat other patient/clients
- To communicate with your provider if your condition worsens or does not follow the expected course
- To provide useful feedback about services and policies
- To provide accurate information about sources of payment
- To fulfill your financial obligations and to pay for care as promptly as possible
- To inform your health care provider of any advanced directives that could affect your care



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Providers at Boise State University Health Services also have certain rights and responsibilities related to the care they provide to patients/clients. Creating a mutually respectful relationship with your provider will enhance the care you receive.

PROVIDER RIGHTS:

- To establish and maintain mutually respectful relationships with their patients/clients
- To consult with other medical and mental health providers within Health Services, when needed, in order to provide the best care for the patient/client
- To terminate a relationship with a patient/client if that patient/client's care is outside of the provider's scope of practice, or if the patient/client displays disruptive behavior, is a safety concern, or creates an ethical dilemma. In these cases, patients/clients will be provided appropriate referrals that would best meet their needs

PROVIDER RESPONSIBILITIES:

- To adhere to all statutes, licensing board rules, and codes of ethics in the provider's field of practice
- To present patients/clients documents related to professional qualifications upon request
- To provide quality services and involve patients/clients in their plan development and evaluation of treatment goals
- To ensure confidentiality of their patient/client's clinical information whenever possible
- To inform the patient/client of provider qualifications, professional disciplines, areas of expertise, and to practice within those standards
- To demonstrate respect regardless of a patient/client's age, race, ethnicity, gender, sexual orientation, religion, and socio-economic status

I have read and understand the rights afforded to me as a patient/client and the responsibilities I have while I receive care.

Printed Patient/Client Name

Date

Patient/Client Signature

University ID Number



Teletherapy Informed Consent Form

I hereby consent to engage in teletherapy counseling services with Boise State University Counseling Services. I understand that "teletherapy" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive live audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in the state of Idaho.

I understand that I have the following rights and understanding with respect to teletherapy:

- 1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- 2) I understand that my clinician is only currently licensed or is a trainee in certain states, and therefore, I will need to attest that I am physically located in one of these states that my clinician is licensed in for each teletherapy session.
- 3) The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I will need to attest that I am in a private, **non-public**, secure place, and alone for each of my teletherapy sessions.
- 4) I understand that the information disclosed by me during the course of my therapy is generally confidential.

However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting abuse **of vulnerable populations**; expressed threats of violence towards an ascertainable victim; **expressed threat to harm or kill self**; and where I make my mental or emotional state an issue in a legal proceeding **or the involvement of law enforcement**.

I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my written consent.

- 5) I understand that there are risks and consequences from teletherapy. This includes, but is not limited to, the possibility, despite reasonable efforts on the part of my counselor, that technical failures could disrupt or distort the transmission of my medical information; unauthorized persons could interrupt the transmission of my medical information; and/or unauthorized persons could access the electronic storage of my medical information. **In the event of a technical failure, I will have a contingency plan in place with my counselor for a back-up mode of communication to close our therapy session and discuss next steps.**

In addition, I understand that teletherapy-based services and care may not be as complete as in-person face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. **Examples include, but are not limited to, crisis situations, severe and persistent mental illness, and medication management.**

Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.



6) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I accept that teletherapy does not provide emergency services. During our first session, the clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. **Examples of emergency situations include, having thoughts of hurting or killing either another person or myself, having hallucinations, being in a life-threatening or emergency situation of any kind, having uncontrollable emotional reactions, or being dysfunctional due to abusing alcohol or drugs.**

I acknowledge I have been told that if I am having suicidal thought or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24 hour hotline support.

I understand that my counselor may ask me to have a ‘collaborator’ on my premises, who is available to contact local authorities in an emergency. A collaborator can be family or friend. My counselor and I will determine who will be designated as my local collaborator, obtain their contact information and consent, discuss their responsibilities, and circumstances for contacting them.

7) I understand that I have a **right to request access to portions** of my medical information and copies of medical records in accordance with Idaho law and HIPAA privacy and security rules.

Client Signature

Date

University ID Number



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Consent to Observe/Record Counseling Services Sessions

Counseling Services at Health Services is a training facility that supports the learning and development of graduate interns and supervised licensed providers. Recording and/or live observation of group and/or individual sessions is part of this program for the purposes of education and training. You are providing your informed consent for observation and/or recording of therapy sessions. If you have any questions about this process, we encourage you to speak with your therapist.

NOTE: Due to the requirements of our training program, you may be reassigned to another provider if you do not give your permission to records your appointments. Your decision not to be recorded/observed will not affect your eligibility for services, but may affect the timeliness of services.

Client Signature

Date

University ID Number



Eating Attitudes Test

Behavioral Questions: In the past 6 months have you:		Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A	Gone on eating binges where you feel that you may not be able to stop?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	Ever made yourself sick (vomited) or withheld food to control your weight or shape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D	Exercised more than 90 minutes or more than once a day to lose or to control your weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	Lost 20 pounds or more in the past 6 months?	No <input type="checkbox"/>	Yes <input type="checkbox"/>				
*Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control							

Hunger Vital Sign

Within the last 12 months, we worried whether our food would run out before we got money to buy more.
(Please circle one below)

Often true Sometimes true Never true Don't know

Within the past 12 months, the food we bought just didn't last and we didn't have any money to get more.
(Please circle one below)

Often true Sometimes true Never true Don't know

I, _____ agree to have my counselor/medical provider communicate with Boise State University's Student Outreach and Assistance team about my desire to be contacted by them to help address concerns about my food insecurity.

- I understand that only students can access this assistance.
- I understand that nothing about my care at Health Services will be shared with the Student Outreach and Assistance team beyond my name, contact information, and desire to receive pertinent assistance provided by their office.

Printed Patient Name

Patient Signature

University ID Number

Date