Student Health and Wellness Center

Consent to Receive Health (Medical and Mental) Services

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Welcome! Welcome to Health (Medical and Mental) Services of the Student Health and Wellness Center [SHWC] at the Illinois Institute of Technology [IIT]. We appreciate you coming our way, and we look forward to working with you. The following provides important information about our services. Please read what follows carefully and sign below. You will be provided with a copy of this information, and it can also be found on the SHWC website [www.iit.edu/shwc].

SHWC offers a wide range of medical and mental health services, including primary health care, medication management, reproductive health care, immunizations preventive care, initial clinical assessments, individual and group psychotherapy, psychiatry, evaluations for readmission, and referral services. Services may be provided by licensed nurse practitioners, physicians, medical assistants, clinical psychologists, and/or psychiatrists, all as appropriate and consistent will applicable laws. Because SHWC is a training facility, some of our clinicians are trainees; however, all clinicians in training are supervised by licensed treatment providers on staff.

Eligibility for Services and Referrals: SHWC provides services to students currently enrolled in at least one credit hour of class. We strive to meet the needs of students. However, there are some services that are not offered, including specialized, long-term, and intensive treatment. If you require services that SHWC does not offer, or if we believe that it is in your best interest to obtain treatment elsewhere, we will provide a referral to an appropriate treatment provider.

Consent for Laboratory Services: By signing this form, you understand and agree to any test(s) taken being sent to Quest Diagnostic Laboratories for processing and analysis. You further understand that Quest Diagnostic Laboratories is NOT affiliated with IIT SHWC and that you will be billed by Quest Diagnostic Laboratories. By initialing below, I am expressly authorizing and requesting IIT SHWC to provide Quest Diagnostic Laboratories with my insurance information, but I realize that the IIT SHWC cannot guarantee payment by the insurance company. I understand that the bill is my responsibility. Please initial: _____

Consent for Sexually Transmitted Disease screening: I represent and warrant that I have read the attached STI intake form and completed it fully and accurately to the best of my knowledge. I understand that I will have the chance to ask questions which will be answered to my satisfaction and the reasonable ability of the provider. By initialing below, I expressly consent to the tests that I have indicated on the STI intake form. I understand the results of my tests will be provided to me in person and that I will be counseled on prevention and risk reduction. I will also be made aware of the disclosure of this test(s) and this information will not, except to the extent required by law, be shared to others without my consent. Any relevant information needed relative to the tests that I have taken (i.e., referrals, pamphlets, brochures, condoms, and such comparable information and items) will be provided to me. Please initial: _____

Consent for taking oral contraceptives and gynecological exam: By initialing below, I expressly acknowledge and agree to the provisions of this section. I acknowledge that information about oral contraceptives (e.g., the pill) and its side effects has been made available to me. I further acknowledge that the initial prescription for the contraceptive drugs and every refill thereafter is and will be provided only at my request. In making this request, I am acknowledge that I aware that such drugs are powerful and effective and should be taken under medical supervision because they can cause serious complications, both known and presently unknown. The most serious known side effect is abnormal blood clotting in the legs, lungs, brain or elsewhere, which could result in complications such as paralysis, loss of sight or death. I agree that it is my responsibility, and hereby assume such responsibility, to inform immediately SHWC (or other medical agency or private physician in the event that the SHWC is closed) of symptoms such as severe leg or chest pain, coughing up blood, difficulty breathing, severe headache, disturbances of vision or speech, weakness or numbness of an arm or leg or unusual medical depression. Please initial: _____

As I am freely choosing to take the contraceptive drugs and to assume the risks associated therewith, I, by initialing below, agree to waive and release and to hold harmless, defend, and indemnify Illinois Institute of Technology and each and every trustee, officer, agent, and employee of IIT from any and all claim, damages, injuries, losses, causes of action, demands, and all cost and expenses arising directly or indirectly from taking oral contraceptives. Please initial: _____

In response to my request to be provided oral contraceptives, I understand that the provided may need to first perform certain examinations to ensure that I am healthy enough to take such drugs, and by initialing below, I consent to a pelvic

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examination, breast check and other examinations as so requested by the medical provider. I understand that in addition to a Pap test I will also be given the option to be screened for Sexually Transmitted Infections. I further agree to return at intervals recommended by the SHWC, which is at least every 6 months for re-evaluation and renewal of oral contraceptives. Please initial: _____

Emergencies: If you experience a medical or mental health crisis during hours of normal operation (generally, during the Fall and Spring semesters, Monday and Friday from 8:30 a.m. – 5:00 p.m.; Tuesday, Wednesday and Thursday from 8:30 a.m. -7:00 p.m.; and Saturday 8:30 a.m. - 12:30 p.m.), you may come directly to SHWC or call 312.567.7550. SHWC staff will do their best to accommodate your need in a timely manner. Please note that psychological triage sessions are brief [20 minutes], and focus on risk assessment and stabilization.

For emergencies that occur outside of such normal hours of operation, please contact IIT Public Safety at 312.808.6363, call 911, or go to the nearest emergency room [the hospital nearest to the Main Campus is Mercy Hospital at 2525 S. Michigan Ave]. Students may also call the Aetna Student Health Insurance Crisis Line at 877.351.7889 [available to all IIT students regardless of insurance plan], or the National Suicide Prevention Lifeline at 800.273.8255.

Confidentiality: What you disclose in your medical appointments, initial assessment, psychotherapy, and psychiatry sessions is rigorously kept confidential within SHWC, and this confidentiality is protected by law. With limited, legally mandated exceptions [see section below], this legally assured confidentiality is the cornerstone of trust between you and your treatment provider. At times, you may give permission to your provider to disclose confidential information so that, for example, your provider at SHWC can consult with your physician at home. Such permission would be given in writing and you would precisely specify the conditions of the disclosure. You may withdraw that permission at any time for any reason; such withdrawal must be made to SHWC in writing.

Limits to Confidentiality for Adults: SHWC may need to disclose and/or be legally required to disclose confidential information without your consent or authorization in specific circumstances, including, but not limited to, the following**:**

- If your provider has grounds to believe that you are at imminent risk of hurting yourself or another person, your provider is required to alert others in order to protect you or others from harm. [Please note: this does not mean every time suicide is discussed in your appointments that your treatment provider will take this action.]
- When there is reasonable suspicion of current abuse or neglect of children as well as adults deemed incompetent.
- If your treatment records are subpoenaed by a court of law through court order.
- Medical providers are mandated to report certain health conditions that may affect public health and safety per state and federal laws.

Appointments: If you cannot attend your scheduled appointment or expect to be significantly [more than 15 minutes] late, please call 312.567.7550 at least 24 hours prior to your appointment time. Failure to attend your appointment without an effort to notify SHWC at least two hours in advance will result in a "no-show fee" of $10 per missed session after the second occurrence. Failure to attend psychiatric appointments without a 24-hour notice will result in a $100 fee for intake appointments and a $50 fee for follow-up appointments.

Fees: Most services offered by SHWC, including general medical appointments, psychotherapeutic appointments, and psychiatric appointments, are free of charge. However, there may be fees associated with certain medical products and procedures, including medications in stock at SHWC, vaccines and STI screenings. Moreover, all laboratory analyses at SHWC are sent off-premises to Quest Laboratories and involve a fee. You may also incur fees if you are in violation of our cancellation policy [please see section above]. You may pay these fees in person at SHWC or online at www.iit.edu/shwc. Failure to pay these fees may result in a hold on your student account.

Process of Psychotherapy: SHWC offers both group and individual psychotherapy. The practice of psychotherapy is based on psychological theory and empirical research, and involves collaboration between you and your therapist for the purpose of addressing personal, relational, or mental health concerns. Your therapist will provide a space for confidential disclosure, support, diagnostic information, and other forms of feedback, as well as ideas for possible alleviation of your concerns, suggestions for reading/education, and referrals to other professionals as needed.

About the Initial Appointment: IIT students interested in receiving psychotherapy or psychiatric services must complete an initial assessment [intake]. During this intake, you will meet with a therapist who will conduct an interview to gather information about the nature of your concerns, your mental health history, personal and family

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history, and other data deemed relevant to help inform your treatment. Based on this assessment, the therapist may recommend a course of therapy that he or she believes in his or her professional judgment is tailored to your needs [e.g. beginning short-term individual therapy at SHWC, joining a therapy group, seeking psychiatric care, or being referred to a clinician off campus].

Length of Treatment: Duration of treatment varies based on your presenting concerns. Psychological concerns are often complex. Many students find relief after 5-10 sessions. Others may wish to meet for longer.

Supervision and Recording: Your therapist may be a doctoral psychology trainee who is supervised by licensed clinical psychologists at SHWC. This supervision is done to ensure the quality of care that you receive while you are in therapy. Supervisors meet with supervised therapists on a regular basis to review the progress of the therapeutic work. For this reason, provided you indicate your consent below, your sessions may be video- or audio-taped to aid in the supervision process. These tapes will be stored on a secure drive, will, to the full extent of the law, not be made public or used for any purposes outside SHWC, and will be destroyed within three weeks of the session. You may revoke your consent for recording at any time with a signed and dated revocation [on the bottom of this page]. Please note that revoking this consent may result in changing therapists.

Psychiatry: SHWC offers psychiatric consultation for students interested in psychotropic medications such as antidepressants or mood stabilizers. Upon referral from your intake therapist, you must complete an initial assessment with the SHWC psychiatrist and then attend ongoing medication management sessions as indicated. SHWC requires students seeing its psychiatrist to also participate in ongoing psychotherapy.

Minors: Under Illinois law, a minor is a person under the age of 18. As a general matter, Illinois law requires a minor who seeks medical treatment to obtain consent from a parent or guardian. There are, however, several exceptions. Some, though not all, of these exceptions are list below. SHWC will provide services to minors consistent with Illinois law.

Emergency Care: A physician may render emergency treatment without the consent of the minor's parent or legal guardian if, in the sole opinion of the physician, it is not feasible to obtain such consent without adversely affecting the minor's condition. *410 ILCS 210/3(a).*

Birth Control: Doctors may provide birth control services and information to minors (under the age of 18 years), without the consent of parents or guardians, if they are married, a parent, pregnant, or referred for birth control services by a physician, clergyman, or a planned parenthood agency, or where a serious health hazard would be created by the failure to provide such services. *325 ILCS 10/1*.

Testing for HIV: Minors may consent to anonymous HIV testing. If a minor's test result is positive, the health care provider shall make a reasonable effort to notify the minor's parent or guardian if, in his or her professional judgment, notification would be in the best interest of the child, and the provider has first sought unsuccessfully to persuade the minor to notify the parent or guardian, or the provider has reason to believe that the minor has not made notification. The law does not create a duty or obligation under which a provider must notify the minor's parent or legal guardian. *410 ILCS 305/9*.

Sexual Assault Victim: Where a minor is the alleged victim of an aggravated criminal sexual assault, criminal sexual assault, aggravated criminal sexual abuse or criminal sexual abuse, the consent of the minor's parent or legal guardian need not be obtained to authorize a hospital, physician, or other medical personnel to furnish medical care or counseling related to the diagnosis or treatment of any disease or injury arising from such an offense. The minor may consent to such counseling, diagnosis, or treatment as if the minor had reached his or her age of majority. *410 ILCS 210/3(b)*.

Treatment for Sexually Transmitted Diseases: Minors 12 years of age or older who may have come in contact with any sexually transmitted diseases (STDs) may give consent to medical care or counseling related to a diagnosis or treatment of the disease. The consent of the parent, parents, or legal guardian shall not be necessary to authorize the medical care counseling. With the minor's consent, anyone involved in providing medical care to the minor, counseling related to the diagnosis, or treatment of the minor's disease shall make reasonable efforts to involve the minor's family in his or her treatment if the person furnishing the treatment believes that the involvement of the family will not be detrimental to the progress and care of the minor. Reasonable effort shall be extended to

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assist the minor in accepting his or her family's involvement in the care and treatment being given. *410 ILCS 210/4.* Any person who provides counseling to a minor patient who has come into contact with any sexually transmitted disease may, but shall not be obligated to, inform the parent, parents, or legal guardian of the minor as to the treatment given or needed. *410 ILCS 210/5.*

Outpatient Mental Health Treatment: Any minor 12 years of age or older may request and receive counseling services or psychotherapy on an outpatient basis without the consent of the minor's parent or guardian. Outpatient counseling or psychotherapy provided to a minor under the age of 17 shall be limited to not more than 5 sessions, a session lasting not more than 45 minutes, until the consent of the minor's parent or guardian is obtained. The minor's parents shall not be informed without the consent of the minor unless the responsible supervising provider believes such disclosure is necessary. The minor's parent or guardian is not liable for the costs of the outpatient counseling or psychotherapy. *405 ILCS 5/3-501.*

Substance Abuse Treatment: Minors 12 years of age or older who may be determined to be an addict, an alcoholic or an intoxicated person or who may have a family member who abuses drugs or alcohol, may give consent to medical care or counseling related to diagnosis or treatment. The consent of the parent, parents or legal guardian shall not be necessary to authorize medical care or counseling. With the minors consent, anyone involved in providing medical care to the minor or counseling related to the drug or alcohol use by the minor or a member of minor's family shall make reasonable efforts to involve the minor's family in his or her treatment, if the person furnishing the treatment believes that the involvement of the family will not be detrimental to the progress and care of the minor. Reasonable effort shall be extended to assist the minor in accepting his or her family's involvement in the care and treatment being given. *410 ILCS 210/4*. Any provider who provides counseling to a minor who abuses drugs or alcohol or has a family member who abuses drugs or alcohol shall not inform a minor's parent, parents, or legal guardian or other responsible adult of a minor's condition or treatment without the minor's consent unless that action is, in the person's judgment, necessary to protect the safety of the minor, a family member, or another individual. *410 ILCS 210/5*.

PLEASE COMPLETE THIS SECTION

I, ____, acknowledge that I have read and understood all of the foregoing information and have had all of my questions answered to my satisfaction. I represent that my date of birth is ___________ ________. I agree to the conditions stipulated in this disclosure document, and I consent to receive services from the staff of SHWC as described herein.

Having read the **Supervision and Recording** section above, I, ____, □ **consent / □ do not consent** to have my therapy sessions video- or audio-taped. [Please note that not consenting to recording will limit the number of potential therapists you can see, thus may result in a longer wait for starting therapy].

______________________	______________________	______________
Student Name/ CWID	Student Signature	Date
If Student is a Minor, Parent/Guardian Name	If Student is a Minor, Parent/Guardian Signature	Date
Witness Name	Witness Signature	Date

••

I, ____, hereby revoke my consent for recording. [Please note that revoking your consent to recording may need to result in changing therapists.]

Student signature: ______________________________________ Date: ____________________________

Witness signature: ______________________________________ Date: ____________________________

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