Conditions of Counseling

Counseling Relationship: Unless you prefer otherwise, I will call you by your first name. During the time you and I work together, we usually will meet weekly for approximately 50-minute sessions. Although our sessions may be psychologically deep, ours is a professional relationship rather than a social one. Therefore, please do not invite me to social events, bring me gifts, ask to barter or exchange services, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling relationship. You will benefit the most if your interactions address your concerns exclusively.

I conduct all counseling session in English or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation. If significant differences, such as in culture or belief system, exist between us, I will work to understand those differences.

Effects of Counseling: At any time, you may initiate with me a discussion of possible positive or negative effects of entering or not entering into, continuing, or discontinuing counseling. I expect you to benefit from counseling. However, I cannot guarantee any specific results. Counseling is a personal exploration that may lead to major changes in your life perspectives and decisions. These changes may affect your significant relationships, job, and/or understanding of yourself. You may feel troubled, usually only temporarily, by some of the things you learn about yourself, or some of the changes you make. In addition, counseling can result in long lasting effects. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, the CCTC may require you to sign a release so I may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services, if I deem it important to do so. By signing this form, you are agreeing to disclose all previous mental health treatment and to reimburse the CCTC for any expenses charged by your previous mental health professional(s) for supplying copies of your records. While you are in counseling with me at the CCTC, you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with me and sign a release that enables me to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against my advice, I may consider this your decision to change counselors and the Community Counseling Training Center at NIU reserves the right to terminate your counseling services.

Appointments and Cancellation: Our in-person contact will be limited to counseling sessions you arrange with me. My scheduled time at the Community Counseling Training Center at NIU is only 5 hours per week.

The Community Counseling Training Center at NIU (CCTC) is a training facility and maintains a strict schedule of services. If you have to miss a session, please call the CCTC at (815) 753-9312 to cancel your session as soon as possible. Please provide your name, the date and time of your session, and your counselor’s name. If you miss two counseling sessions without notifying the CCTC, your services will be terminated. If you are a student seeking extra credit for participating in counseling services, you must
attend a minimum of four sessions to receive your extra credit. If you are terminated you may reapply for services, pending counselor availability, however you will be required to complete four consecutive sessions.

X _____ I have read the above statements and understand the procedures regarding cancellation.

**Permission to Participate and Confidentiality:** I am a counselor-in-training in the counseling program at Northern Illinois University and am under the direct supervision of supervisors listed on page one (whom may be contacted at (815) 753-9312. All our counselor sessions are confidential. This means that no information will be released to persons or agencies regarding the fact that counseling has been received or the nature of the concerns without written consent. Danger to self and/or others (i.e. suicide or homicide) may necessitate the breaking of confidentiality. In addition, by law suspected child abuse and/or neglect and elder abuse and/or neglect communicated by clients must be reported to appropriate agencies by counseling staff.

X _____ I have read the above statements and understand my rights regarding my participation and confidentiality.

**Recording and Observation:** Counselors-in-training receive consultation and supervision. To aid in this, I must request to have your sessions recorded and/or observed. Information and recordings will be treated according to ethical standards. Confidentiality will be strictly maintained; information will not be released to any other person or agency without your written permission. In accordance with Illinois state laws, written records will be maintained for the appropriate length of time and then properly destroyed. Please read the statement below and sign if you agree. If you have questions, please talk them over with me.

X _____ I agree to the recording and/or observation of my sessions. I understand that confidentiality will be maintained, written records will be maintained, and that professional ethical standards will be observed in this process. I also understand that I may request the identities of all individuals observing my recorded counseling sessions. Recordings will be erased following supervision.

**Crises:** The Community Counseling Training Center at NIU is not equipped for after-hours emergencies. Any messages on the CCTC answering machine after Thursdays’ hours will not be heard until Monday afternoon. If a need arises and assistance is required immediately, please contact the University Police at (815) 753-1212. If you are not a student at NIU, contact the Ben Gordon 24-Hour Community Crisis Hotline at (866) 242-0111.

X _____ I have read the above statements and understand the procedures regarding emergency situations.

In the event that I believe you are in danger, physically or emotionally, to yourself or another person, you specifically consent for me to warn the person in danger and to contact the following person(s), in addition to medical and/or law enforcement personnel:

Name ____________________________ Telephone Number ___________________
Client Rights

Some clients achieve their goals in only a few counseling sessions, whereas others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. If you choose to end the counseling relationship, I ask that you participate in a termination session. You also have the right to refuse or to discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. I render counseling services in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to my supervisor(s) listed on page one. As a client you have the right to:

- Be informed of the qualifications of your counselor: education, experience, and professional counseling certification(s) and State license(s).
- Receive an explanation of services offered, your time commitments, fee scales and billing policies prior to receipt of services.
- Be informed of limitations of the counselor’s practice to special areas of expertise (e.g., career development, ethnic groups, etc.) or age group (e.g., adolescents, older adults, etc.).
- Have all that you say treated confidentially and be informed of any state laws placing limitations on confidentiality in the counseling relationship.
- Ask questions about the counseling techniques and strategies and be informed of your progress.
- Participate in setting goals and evaluating progress towards meeting them. Be informed of how to contact the counselor in an emergency situation.
- Request referral for a second opinion at any time.
- Request copies of records and reports to be used by other counseling professionals.
- Request to review your records, and make amendments.
- Receive a copy of the code of ethics to which your counselor adheres.
- Contact the appropriate professional organization if you have doubts or complaints relative to the counselor’s conduct.
- Terminate the counseling relationship at any time.
- If you have any concerns about your rights, you may contact your counselor’s supervisor or the Community Counseling Training Center Coordinator.

Privacy Rights under HIPAA: You have the right to review your client file in the presence of your counselor, the supervisor, or the Clinical Director. You may ask for a copy of your file and will be charged a per-page copy fee at the current university copying rate. You may ask for corrections or clarifications of the content in the file and that will be recorded in the notes. You may ask to review the CCTC HIPAA procedures. You may also ask for a meeting with a HIPAA compliance officer (the Clinical Director).

X _____ I have been informed of my privacy rights under HIPAA and understand how to access my client file.

Client Responsibilities

- Set and keep appointments with your counselor. Let him/her know as soon as possible if you cannot keep an appointment or are running late.
- Help plan your goals.
- Follow through with agreed upon goals.
- Keep your counselor informed of your progress toward meeting your goals.
- Terminate your counseling relationship before entering into arrangement with another counselor.
X _____ I have been informed of my consumer rights and responsibilities as a client.

**Referrals:** The CCTC staff recognizes that not all conditions presented by clients are appropriate for treatment at this facility. For this reason, you and/or I may believe a referral is needed. In such a case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives. I most likely will be available to be your counselor at the CCTC until the end of this current academic semester. If you wish to continue counseling beyond that time, I will provide limited continuation or referral options.

By your signature below, you are indicating that you read and understand this statement, that any questions you had about this statement were answered to your satisfaction, and that you were furnished a copy of this statement. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

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