



COUNSELLING SERVICES

Welcome to Mount Saint Vincent University's Health and Wellness' Counselling Services office. Our collaborative Health and Wellness practice includes physicians, counsellors, a registered nurse, and other Health and Wellness staff. This intake form contains important information about Counselling Services policies and practices, as well as questions for you as a new client. It also asks for your consent for various information-sharing practices. *Please read it carefully and ask your counsellor for assistance if you have any questions.*

Student Information

Legal Name: _____

Chosen Name: _____

Pronoun: _____

Student #: _____

Date of Birth (DD/MM/YYYY): _____

Current Phone #: _____

MSVU Email: _____

Current Address: _____

Program and Year of Study: _____

Primary Physician: _____

Emergency Contact: _____

Relationship to You: _____

Phone #: _____

Introduction

Please take time to read and understand this form. This informed consent document is intended to give you information about Mount Saint Vincent University's Counselling Services.

Nature of Counselling

Your first appointment will provide you with an opportunity to talk confidentially with an intake worker or counsellor who will talk with you about some of the reasons you scheduled the appointment and will evaluate what ongoing services or resources would be most helpful for you. You have the right to ask about or to decline any part of your counselling. You also have the right to request another counsellor.

Emergencies

If you find yourself in an emergency situation, (i.e., thoughts of harming yourself or others, or thoughts of committing dangerous acts), please visit the nearest hospital emergency room or call 911.

Supervision of Interns

Counselling Services supervises Masters level counselling interns. Counselling interns have the ability to provide counselling to clients and they are supervised by the Interim Manager of Counselling Services. You have the right to know the name of your counselling intern's supervisor(s) and how to contact them. Due to interns being in training, the supervisor may ask you and/or the interns about counselling sessions for supervisory and training purposes. The supervisor will keep this information confidential.

Supervisor: Kyle Cleversey, MA, CCC, RCT, Interim Manager, Counselling Services.

Privacy, confidentiality and your personal information

- At Counselling Services, we collect personal information from our clients in order to provide safe, effective care. Personal information includes your legal name, address, chosen name, date of birth, etc.
- Counselling Services is committed to protecting the privacy of your personal information and our staff understand the importance of maintaining client confidentiality. Our staff receives training in privacy and confidentiality and our records are kept on a secure electronic health records system. Each user has a unique ID and password and regular audits of user access are conducted.

- Your personal information will be treated as confidential by our team and is shared within our collaborative practice team on a need-to-know basis. Disclosure of your personal information outside of our service is only done with your consent, unless the disclosure is permitted or required by law. We are required to disclose personal information outside of Counselling Services without your consent to comply with standard legal requirements such as preventing clients from seriously physically harming themselves or others, court subpoenas, and the prevention of child abuse and elder abuse.

Use of Technology for Electronic Counselling (E-counselling)

When appropriate, technology may be used to conduct counselling sessions, such as the telephone or video conferencing on a secure platform. Counselling Services is committed to protecting the confidentiality of our clients and follows the ethical standards of the Canadian Counselling and Psychotherapy Association's Standards of Practice for e-counselling. Even while following these ethical standards, Counselling Services cannot guarantee absolute confidentiality while using technology.

☐ Yes, I understand and accept the confidentiality risk that is associated with participating in electronic counselling sessions.

Initials _____

Collection, use and disclosure of your personal information

We collect, use and disclose your personal information as needed in order to:

- Evaluate your mental health care needs and provide care to you.
- Consult with other Student Health and Wellness health care providers (such as physicians or the nurse in our Health Office) from time to time, if such consultation is considered beneficial to you.
- Conduct quality improvement and risk management activities.
- Fulfil other purposes permitted or required by law, e.g. reporting abuse.

Disclosure of personal information with parent/guardians

We do not share your personal information with your parents or guardians without your consent. Please note that in event of an emergency situation on campus, we may contact (and provide information on a need-to-know-basis) to your listed emergency contact person.

Masking Options in our Electronic Health Record

Our health professionals and staff are only authorized to access your electronic health record on a need-to know basis for the purposes described above. Our electronic health record system offers our patients the option of locking their counselling file which would require anyone accessing your information on a need-to-know basis to first obtain your consent and/or enter into the system a reason for accessing confidential materials. However, the best quality of healthcare can be delivered to you when you share your health records with our full health professional team.

Please note that your contact information and record of appointments cannot be locked. **Please indicate your preference:**

☐ Please lock my counselling file.

Initials _____

☐ Please allow professionals employed at MSVU Health and Wellness access to my file on a need-to-know basis.

Initials _____

Review

I have reviewed and understand the above information. I consent to Counselling Services collecting, using, and disclosing my personal information as described above, and in accordance with my chosen preferences. I understand I can change or withdraw my consent at any time by submitting a "Consent Change Form" that is available from Counselling Services' front desk staff.

Click here to accept: OR sign here: _____

Print name: _____

Date: _____

Missed Appointment Policy:

- Please notify us as soon as possible when you have to cancel an appointment, as we can then offer that time to someone else waiting for care. Three missed counselling appointments in a row with a counsellor will require the client to contact the counsellor by phone or email to identify how you will prevent missing your appointment in the future, prior to being allowed to book another appointment.

Initials _____

Governing Law & Jurisdiction

- I hereby agree that the resolution of any and all disputes arising from myself and either Mount Saint Vincent University or the healthcare providers (as well as employees, and other independent healthcare providers providing healthcare and treatment to me) at Counselling Services, shall be governed within the laws of the Province of Nova Scotia.
- I hereby acknowledge that the Standards of Practice of the Canadian Counselling and Psychotherapy Association and the Nova Scotia College of Counselling Therapists will

be followed. I acknowledge that the Nova Scotia College of Counselling Therapists shall have jurisdiction over any complaint made against a registered member of that College. I hereby agree that if I commence any legal proceedings that they will be only in the Province of Nova Scotia with exclusive jurisdiction of the Courts of Nova Scotia.

- Mount Saint Vincent University is committed to the protection of your personal information. Any personal information you provide will be collected, disclosed, retained, and disposed of in accordance with the conditions stated on this form, and in compliance with Nova Scotia's Personal Health Information Act (PHIA), and regulations, as amended.

Initials _____

I have reviewed and understand the above information and conditions.

Click here to accept: OR sign here: _____

Print name: _____

Date: _____