Counseling & Psychological Services (CAPS)
University of California, San Diego

INTAKE FORMS PACKET

Included in this Packet

(1) Information & Consent Form (2 copies, pp. 2-3)
(2) Intake Questionnaire (pp. 4-8)
(3) Notice of Privacy Practices (pp. 9-15)
(4) Acknowledgment of Receipt of NPP (p. 16)

Instructions

Before your Appointment:

(1) Read and Sign/Date the ***Office Copy*** of the **Information & Consent Form**
(Keep the *Student Copy* that is printed for you)
(2) Complete the **Intake Questionnaire**
(3) You may review the **Notice of Privacy Practices (NPP)**
(4) Sign/Date the **Acknowledgment of Receipt of NPP**

Bring to your Appointment:

(1) The signed *Office Copy* of the **Information & Consent Form**
(2) The completed **Life Functioning Inventory**
(3) The signed **Acknowledgment of Receipt of NPP**

If you have any questions regarding these forms, please call (858) 534-3755.

UNIVERSITY OF CALIFORNIA, SAN DIEGO
COUNSELING & PSYCHOLOGICAL SERVICES
(858) 534-3755

Name ______________________

Student ID A ______________________

INFORMATION AND CONSENT FORM

OFFICE COPY

Services Provided

UCSD Counseling & Psychological Services (CAPS) offers a variety of individual, couples, and group counseling services provided by psychologists, psychiatrists and post doctoral psychology fellows.

Eligibility for evaluation or treatment from CAPS is contingent upon status as a fully enrolled UCSD student paying the Student Services Fee.

Counseling and psychotherapy can have both risks and benefits. The counseling process may include discussions of your personal challenges and difficulties which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. However, counseling has also been shown to have many benefits. It can often lead to better interpersonal relationships, improved academic performance, solutions to specific problems and reductions in your feelings of distress. But, there is no assurance of these benefits.

Confidentiality

In keeping with ethical standards of the American Psychological Association and state and federal law, all services provided by the staff of CAPS are kept confidential except as noted below and in the accompanying *Notice of Privacy Practices.* We consult as needed within the staff of CAPS about the best way to provide the assistance that you might need. Although CAPS and SHS use the same electronic medical record system, your counseling records are kept separate and private from SHS unless collaborative care is needed. If you do not wish your records shared with SHS, inform your CAPS counselor so we can keep access to your counseling information exclusive to CAPS staff. As required by psychological practice guidelines and current standards of care, we keep records of your counseling. Storage of these paper and electronic records meet federal standards for security. Neither the fact that you seek counseling nor any information disclosed in the counseling sessions will appear in your student academic record unless you specifically direct us to communicate with other staff and faculty at the university.

CAPS professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself and when there is a valid court order for the disclosure of client files. Fortunately these situations are infrequent. By signing this form you also give CAPS permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. Please consult with your psychologist if you have any questions about confidentiality.

Counseling Policies

Although we try to arrange initial counseling appointments promptly, a waiting list is common during busy periods of the year. If you consider your situation an emergency that will not allow a delay, please inform our staff. For after-hours urgent needs, call our central office number at 858 534 3755 and select option #2 to speak immediately with a mental health counselor. If you have an emergency where you or someone else is at risk, call 911 or go to the nearest emergency room.

Many issues typically encountered by university students can be addressed with the short-term counseling that we provide. Your initial session is an assessment session, devoted to defining your concerns, developing a treatment plan, and determining whether CAPS can meet your needs. If at any point it is determined that other services are more suitable, we will help you obtain assistance from appropriate off-campus providers utilizing your comprehensive healthcare insurance that is required while attending UCSD.

Non-compliance with the plan we develop to assist you could result in the termination of services.

Please arrive on time for your appointments. Missed appointments reduce our capacity to provide services to other students. If you are unable to keep your appointment, please call to cancel as far in advance as possible.

Cancellations within 24 hours and missed appointments (no-shows) will incur a charge of $20 to your Bursar's Account. There is no charge for appointments that you attend or cancel sufficiently in advance. Repeated cancellations or missed appointments may result in the termination of counseling.

Our goal is to provide the most effective psychotherapeutic experience. If you feel that your counselor is not a good match for you, we encourage you to discuss this matter with your current counselor. Alternatively, you can speak with the Clinical Director of CAPS. Either of the above can facilitate a transfer to a different counselor, if necessary. If you have questions or comments about our services, please ask at your initial appointment, fill out a Client Experiences Survey (CES) or arrange to speak with our Director.

CAPS is a training site for psychologists

The counseling you receive may be from a post-doctoral fellow in psychology. Our postdoctoral fellows are supervised by licensed psychologists and will inform you of the name and contact information for their supervisor who can be contacted through our central office.

Use of electronic mail

In order to assure your privacy, CAPS staff are not permitted to communicate with students using e-mail. If you need to communicate with your counselor regarding scheduling, please (1) telephone them directly with the number provided to you at your first meeting, or (2) use our secure online messaging system at the UCSD CAPS/SHS web portal (**https://shs.ucsd.edu**). For all other communications, please telephone your Counselor.

Psychiatry

CAPS offers initial comprehensive psychiatric evaluation, risk assessment, psychopharmacologic assessment, interim medication management, and psychiatric consult-liaison services. Students must be in treatment with a Primary Care Provider (PCP) located at SHS or CAPS [PCP includes: psychologist, post-doctoral psychology fellow, primary care physician, nurse practitioner, social worker]. After initial consultation, most students are referred to off-campus providers, using the student's health insurance.

Psychiatric Medications

New medications will be prescribed only during psychiatry medication office visits, so that your psychiatrist can perform a current assessment of your condition and discuss with you the risks and benefits that may be associated with a new medication, and its alternatives.

It is your responsibility to request medication refills in a timely manner. If you need a prescription refilled, it is strongly preferred that you request a new prescription from your psychiatrist during a scheduled office visit. This allows your psychiatrist to re-evaluate your condition and address any of your concerns. If you run out of your medication prior to your scheduled psychiatry visit, contact your psychiatrist. Please allow 5 business days for refill requests to be processed, and be aware that some medications cannot be legally refilled via telephone. Routine medication refills are authorized only during regular business hours.

Please sign below to indicate that you understand and agree to participate in counseling in accord with the above policies.

Print Name	Signature	Date

UNIVERSITY OF CALIFORNIA, SAN DIEGO
COUNSELING & PSYCHOLOGICAL SERVICES
(858) 534-3755

Name ____________________

Student ID A ____________________

INFORMATION AND CONSENT FORM

STUDENT COPY

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Please sign below to indicate that you understand and agree to participate in counseling in accord with the above policies.

____________________	____________________	____________
Print Name	Signature	Date

01/01/2016

UC San Diego Counseling & Psychological Services (CAPS)
Student Information Form

First Name:______________________________ MI:__________ Last: ______________________________

Birth date:________/__________/________ (day / month / year) Current Age: __________ Student ID#: ______________________________

SECTION A: STUDENT INFORMATION

(A1) GENDER: ☐ Female ☐ Male ☐ Transgender ☐ Other (identify) _______

(A2) ETHNICITY

☐ African/American
☐ Chicano/Mexican American/Puerto Rican
☐ Chinese/Chinese American
☐ East Indian/Pakistani
☐ Filipino
☐ Japanese/Japanese American
☐ Korean/Korean American
☐ Latino/Latino American/Hispanic
☐ Middle Eastern
☐ Native American/Alaskan Native
☐ Polynesian/Micronesian
☐ Vietnamese/Vietnamese American
☐ White/Caucasian
☐ Multiracial/Multiethnic
☐ Other (____________________)
☐ Prefer Not to Answer

(A3) SEXUAL ORIENTATION:

☐ Bisexual ☐ Heterosexual ☐ Lesbian/Gay ☐ Queer ☐ Questioning ☐ Other (identify) ____________________

(A4) RELATIONSHIP STATUS:

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other (specify) ____________________

(A5) RESIDENCE (check and specify in detail below):

☐ Residence Hall/Apartment ____________________ ☐ Graduate Student Housing

☐ Fraternity/Sorority ☐ Off-campus Residence

☐ Parent's/Relative's Home ☐ Other ______________________________

Local Residence Address: (e.g. Tioga Hall, Muir College, Street, City, State, Zip)

____

(A6) CONTACT INFORMATION (check all that apply):

Cell Phone #: ______________________________ ☐ OK to phone ☐ OK to leave message

Home or other Phone #: ______________________________ ☐ OK to phone ☐ OK to leave message

Preferred E-mail address: (Please be aware that email might not be confidential.) ______________________________

☐ OK to email you regarding your appointment

☐ OK to email you an evaluation survey regarding your experience with courseling

(A7) PREFERRED METHOD OF CONTACT:

☐ Cell Phone ☐ Home Phone ☐ Email ☐ Mail ☐ Other (specify) ____________________

(A8) EMERGENCY CONTACT:

Name: ____________________ Relationship: ____________________ Phone: ____________________

Address: ____

(A9) ACADEMIC STATUS:

☐ Fr ☐ SO ☐ JR ☐ SR ☐ Grad Student ☐ Medical Student ☐ SIO Student

☐ Pharmacy School ☐ Rady School ☐ Student's Spouse/ Partner ☐ Other ____________________

If you are a GRADUATE STUDENT, please specify the type of degree: ☐ Masters ☐ Doctorate ☐ Other __________

(A10) ACADEMIC INFORMATION:

Major/Academic Department ______________________________ Units this Quarter ____________

High School GPA __________ Community College GPA (if applicable):____________________ UCSD GPA __________

(A11) ARE YOU CURRENTLY EMPLOYED?

☐ Yes ☐ On-Campus ☐ Off-Campus ☐ Number of hours worked per week ____________

☐ No

(A12) CO- or EXTRA-CURRICULAR ACTIVITIES: (please list below)

____
____
____

(A13) UCSD UNDERGRADUATE COLLEGE:

☐ Revelle ☐ Muir ☐ Marshall ☐ Warren ☐ Roosevelt ☐ Sixth College ☐ N/A

(A14) OTHER INFORMATION: (check YES for those groups that apply to you and answer corresponding follow-up questions)

a) VETERAN ☐ Yes – Branch of Military ____________ Time of Service: ____________ ☐ No

b) INTERNATIONAL STUDENT ☐ Yes – Country ____________ ☐ No

c) TRANSFER STUDENT ☐ Yes (specify below) ☐ No

Transfer from: ____________ ☐ 2-Yr Institution ☐ 4-Yr Institution

d) STUDENT WITH DISABILITIES: ☐ Yes (specify below) ☐ No

If yes, are you officially diagnosed? ☐ Yes - Diagnosis: ____________ ☐ No

Are you officially registered with the UCSD Office with Student Disabilities (OSD) program? ☐ Yes ☐ No

e) FIRST IN YOUR IMMEDIATE FAMILY TO ATTEND COLLEGE (excluding siblings): ☐ Yes ☐ No

f) HAVE YOU EVER BEEN IN ANY CATEGORY OF ACADEMIC DIFFICULTY WHILE AT UCSD? ☐ Yes ☐ No

If YES, check if applicable: ☐ Academic Probation ☐ Subject to Dismissal ☐ Other

(A15) REFERRED BY: (check all that apply)

☐ Self (see below) ☐ Professor/TA ☐ Friend ☐ Dean ☐ Academic Advisor
☐ Student Health ☐ Medical Provider ☐ Parent ☐ Other (specify) ____________

If Self, how did you hear about our services?

☐ Our Website ☐ TritonLink Website ☐ Other Website ☐ Orientation ☐ Presentation
☐ Library Walk Event ☐ Other

(A16) HEALTH INSURANCE COVERAGE:

☐ SHIP (University Plan) ☐ Private Insurance (specify name of insurance plan) ____________

SECTION B: PRESENTING CONCERNS

(B1) Briefly describe what brings you to the Counseling and Psychological Services (CAPS):

____

(B2) Approximately how long has this concern been bothering you?

☐ Day ☐ Week ☐ Month ☐ Several months ☐ Year ☐ Several years ☐ Most of my life

(B3) Please CHECK ITEMS THAT APPLY. Check only those which apply to your presenting concern(s):

☐ a) Academic concerns
☐ b) Addictions
☐ c) ADHD/learning problems
☐ d) Adjustment to UCSD
☐ e) Adjustment to new situations
☐ f) Alcohol or drug concerns
☐ g) Anger management
☐ h) Anxiety, fear, nervousness
☐ i) Career/job concerns
☐ j) Compulsive Behavior
☐ k) Concentration difficulties
☐ l) Concern with other's well-being
☐ m) Cultural/multicultural concerns
☐ n) Cutting or self injury
☐ 0) Depression, sadness
☐ p) Discrimination
☐ q) Eating concerns/body image
☐ r) Emotional or psychological abuse
☐ s) Episodes of manic behavior
☐ t) Faculty/advisor concerns
☐ u) Family problems
☐ v) Feeling doomed or helpless
☐ w) Financial concerns
☐ x) Graduation preoccupations
☐ y) Harassment
☐ z) Identity/sense of self
☐ aa) Impulse control
☐ bb) Internet/videogame concerns
☐ cc) Intimate relationship concerns
☐ dd) Interpersonal concerns
☐ ee) Legal concerns
☐ ff) Loneliness
☐ gg) Loss, grief, death
☐ hh) Self-esteem
☐ ii) Medical or health concerns
☐ jj) Mood swings
☐ kk) Obsessive thoughts
☐ ll) Panic Attacks
☐ mm) Paranoia
☐ nn) Phobias
☐ oo) Physical abuse or assault
☐ pp) Procrastination
☐ qq) Re-entry concerns
☐ rr) Relationship concerns
☐ ss) Sexual abuse or sexual assault
☐ tt) Sexuality concerns
☐ uu) Sleep difficulties
☐ vv) Spiritual or religious concerns
☐ ww) Stress or tension
☐ xx) Thinking about suicide
☐ yy) Thoughts racing through your mind
☐ zz) Trouble making decisions or getting things done
☐ aaa) Other presenting concern (specify below)

____

For Question #B4, use the following scale:

Low Intensity: 1-----2-----3-----4-----5: High Intensity

(B4) Please indicate by letter, which of the above concerns are most important to you: (e.g., "c", "gg", "mm")

	Rate the Intensity of this concern					Rate your current level of distress regarding this concern				
Most Important: ________________	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Second Most Important: ____________	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Third Most Important: ____________	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

SECTION C: LEVEL OF IMPACT

(C1) How much do your concerns interfere with your: (use scale below)

Low Interference: 1-----2-----3-----4-----5: Severe Interference

Academic Performance :
Low: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5:** Severe

Emotional Well-being:
Low: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5:** Severe

Social Relationships/Social Activities:
Low: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5:** Severe

Daily Routine:
Low: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5:** Severe

(C2) Due to the impact of your concerns on your Academic Performance, are you considering:

☐ Withdrawing for the quarter ☐ Not enrolling next quarter ☐ Dropping Out ☐ Transferring

☐ Other: (specify) ____ ☐ Not Applicable

SECTION D: MENTAL HEALTH HISTORY

(D1) Have you received counseling or psychotherapy in the past:

☐ Never ☐ Prior to high school ☐ High school ☐ Before attending UCSD ☐ at UCSD

(D2) Are you a returning client to UCSD Counseling and Psychological Services (CAPS)?

☐ Yes (specify below) ☐ No

If YES, when did you receive counseling services at CAPS, and who was the mental health provider/counselor:
(e.g., :Fall 2002, Dr. Psychologist name") _____

(D3) Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

☐ Yes (specify below) ☐ No

If YES, please provide the mental health provider's name and phone number:
(e.g., :"Dr. Provider Name, 555-555-5555") _____

(D4) Have you been proscribed psychiatric medication in the PAST?

☐ Yes (specify below) ☐ No

If YES, were you prescribed psychiatric medication at any time prior to your attendance at UCSD?

☐ Yes ☐ No

Please list what medications, dosage, and when taken:
(e.g., "Prozac, 20mg, 2002-2004") _____

(D5) Are you CURRENTLY taking prescribed psychiatric medication, antidepressants, or others?

☐ Yes (specify below) ☐ No

If YES, please list any psychiatric medications you are CURRENTLY taking and the prescribing psychiatrist/physician:
(e.g., "Prozac, 20mg, Family Doctor") _____

Are the medications helpful?
☐ Yes ☐ No

(D6) Have you been hospitalized for psychiatric reasons? ☐ Yes (specify below) ☐ No

If YES, please specify reason for past hospitalization: (check all that apply):

☐ Psychological problems ☐ Suicide ideation/attempt ☐ Dangerousness to others ☐ Drug/alcohol ☐ Other (specify below)

Please specify when and where you were hospitalized: (e.g., "2002, Hospital Name")_____

If you marked OTHER above, also describe the reason for your hospitalization: _____

Was the hospitalization helpful? ☐ Yes ☐ No

(D7) Have you ever had thoughts of harming yourself? ☐ Yes ☐ No

(D8) Have you purposely injured yourself without suicidal intent? (e.g., cutting, hitting, burning, etc.) ☐ Yes (specify below) ☐ No

If YES, when did this occur? ☐ In the past but stopped ☐ In the past and currently going on ☐ Recently started

(D9) In the last few days, have you had suicidal thoughts? ☐ Yes (specify below) ☐ No

If YES, answer the following questions:

FREQUENCY: ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

DURATION: ☐ Seconds ☐ Minutes ☐ Hours ☐ Constant

INTENSITY: ☐ Brief and fleeting ☐ Focused deliberation ☐ Intense rumination

(D10) Have you seriously considered attempting suicide in the past? ☐ Yes (specify below) ☐ No

If YES, please describe: (e.g., age, issues, what happened) _____

(D11) Have you made a suicide attempt? ☐ Yes (specify below) ☐ No

If YES, please describe when and the nature of the attempt: _____

Did you receive help?☐ Yes (specify below) ☐ No

If YES, please describe when and the nature of the help you received: _____

(D12) Have you seriously considered harming another person? ☐ Yes (specify below) ☐ No

If YES, describe when, who, and how: _____

(D13) Have you ever intentionally physically harmed someone? ☐ Yes (specify below) ☐ No

If YES, describe when, who, and how: _____

(D14) Do you CURRENTLY have thoughts of harming another person? ☐ Yes (specify below) ☐ No

If YES, please describe: _____

SECTION E: SUBSTANCE USE

(E1) Do you regularly use alcohol? ☐ Yes (specify below) ☐ No

(E2) In a typical month, how often do you have 4 OR MORE DRINKS in a 24-hour period?

☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

(E3) Do you consider your alcohol consumption a problem? ☐ Yes ☐ No ☐ Not Applicable

(E4) Have you used any drug in the past 30 days that was not prescribed by a doctor? (e.g., marijuana, meth, cocaine, diet pills, ecstasy, Xanax, valium, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, or other) ☐ **Yes (specify below)** ☐ **No**

If YES, indicate which substance(s) and when:

(E5) How often do you engage in recreational drug use? ☐ **Never** ☐ **Rarely** ☐ **Monthly** ☐ **Weekly** ☐ **Daily or Almost Daily**

(E6) Do you consider your drug use a problem? ☐ **Yes** ☐ **No** ☐ **Not Applicable**

(E7) Have you ever received treatment for alcohol or drug use? ☐ **Yes (specify below)** ☐ **No**

If YES, indicate when, where, and substance(s)

Was it helpful? ☐ **Yes** ☐ **No**

(E8) What is your typical DAILY CAFFEINE intake?

☐ **Never or infrequently** ☐ **12-24oz OR 1-2 cups/servings** ☐ **25-60 oz OR 3-5 cups/servings** ☐ **More than 60oz OR 5+ cups/servings**

(E9) What is your typical DAILY NICOTINE intake?

☐ **Never or infrequently** ☐ **Less than 5 cigarettes** ☐ **5-20 cigarettes** ☐ **More than 20 cigarettes** ☐ **Other (e.g., nicotine patch)**

SECTION F: HEALTH & SOCIAL ISSUES

(F1) When was your last physical exam?_____

(F2) How is your physical health at present? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

(F3) Have you had any serious accidents, injuries, or illnesses?? ☐ Yes (specify below) ☐ No

If YES, please describe: _____

(F4) Are you presently taking any medications? (e.g., prescribed medications, over-the-counter drugs, alternative remedies, etc.)

☐ Yes (specify below) ☐ No If YES, please list: _____

(F5) Please list any PERSISTENT PHYSICAL SYMPTOMS or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, etc.)

_____

(F6) Are you having any problem with your sleep habits?
☐ **No problems** ☐ **Sleeping too much** ☐ **Sleeping too little** ☐ **Poor quality of sleep** ☐ **Disturbing dreams**
☐ **Other (please describe)**

(F7) How many times per week do you exercise? ☐ **One or less** ☐ **Two to Four** ☐ **Five or more**
For about how long each time?

(F8) Are you having difficulty with appetite or eating habits?
☐ **No difficulty** ☐ **Eating less** ☐ **Eating more** ☐ **Binging** ☐ **Restricting** ☐ **Significant weight change**
☐ **Other (specify below)**
Please describe the nature of your eating habits or weight change:
(e.g., frequency of eating patterns, how much weight lost and time frame, etc .

(F9) Do you have any problems or worries about sexual functioning? (check all that apply)
☐ **No concerns** ☐ **Lack of desire** ☐ **Performance problem** ☐ **Sexual impulsiveness**
☐ **Difficulty maintaining arousal** ☐ **Worried about sexually transmitted disease** ☐ **Other (specify below)**
If OTHER, please describe:

(F10) Besides family members, approximately how many people can you really count on right now for friendship and emotional support?

(F11) Approximately how many significant intimate relationships (lasting 6 months or more) have you been involved in the last couple of years?

(F12) Are you in a significant intimate relationship now?

SECTION G: FAMILY & CULTURAL BACKGROUND

(G1) Please list the members of your current family, including ages and occupations(e.g., "Mother, 50, accountant")

(G2) Were you and both your parents born in the USA? ☐ Yes ☐ No (specify below)
If NO, please describe who was foreign-born, where, and what was the approximate age of immigration: _____

(G3) In general, how happy or adjusted were you growing up?
☐ Not at all ☐ Unsatisfactory ☐ Average ☐ Substantially ☐ Completely

(G4) Does your family speak a language other than English at home? ☐ No ☐ Very little ☐ Sometimes ☐ Moderately ☐ Strongly
If YES, what language(s): _____

(G5) What is your ethnic identity? _____

(G6) How much do you identify with your ethnic heritage? ☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Strongly

(G7) How much conflict in values do you currently experience with your parents?
☐ Very little or none ☐ Some ☐ Moderate ☐ Strong ☐ Extreme

(G8) Religious preference: _____ **Are you currently active in your religion**? ☐ Yes ☐ No

(G9) How much is your immediate family a source of emotional support for you?
☐ Not at all ☐ A little ☐ Somewhat ☐ Substantial ☐ Very strong

(G10) Have you personally experienced LEGAL PROBLEMS? ☐ Yes ☐ No
If YES, please describe: _____

(G11) Did you experience LEARNING PROBLEMS in elementary or high school?
☐ None ☐ A little ☐ Some ☐ Substantial ☐ A lot, constant struggle

(G12) Do you have children? ☐ Yes ☐ No **If YES, please list age and gender of children**: _____

(G13) Please check any past, present, or impending special problems in your family. Please specify the problem, family member(s), and time of occurrence:
☐ a) DIVORCE/MARITAL PROBLEMS ☐ b) SERIOUS PHYSICAL ILLNESS, DISABILITY, OR DEATH ☐ c) ALCOHOL/SUBSTANCE ABUSE PROBLEMS
☐ d) PSYCHIATRIC ILLNESS/EMOTIONAL PROBLEMS ☐ e) FINANCIAL PROBLEMS/UNEMPLOYMENT ☐ F) LEGAL PROBLEMS
☐ g) OTHER _____

Effective Date: September 23, 2013

NOTICE OF PRIVACY PRACTICE

COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS)
UNIVERSITY OF CALIFORNIA SAN DIEGO

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

UC HEALTH SYSTEM

UC San Diego Counseling and Psychological Services (CAPS) is one of the health care components of the University of California. The University of California health care components consist of the UC medical centers, the UC medical groups, clinics and physician offices, the UC San Diego professional school(s) departments engaged in clinical care, Student Health and Well-being Services, and the administrative and operational units that are part of the health care components of the University of California.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

UC San Diego CAPS is committed to protecting medical, mental health and personal information about you ("Health Information"). We are required by law to maintain the privacy of your Health Information, provide you information about our legal duties and privacy practices, inform you of your rights and the ways in which we may use Health Information and disclose it to other entities and persons.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following sections describe different ways that we may use and disclose your Health Information. Some information, such as certain drug and alcohol information, HIV information, genetic information and mental health information is entitled to special restrictions related to its use and disclosure. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories. Other uses and disclosures not described in this Notice will be made only if we have your written authorization.

For Treatment. We may use Health Information about you to provide you with medical and mental health treatment or services. We may disclose Health Information about you to doctors, nurses, technicians, trainees, or other health system personnel who are involved in taking care of you in the health system. A doctor treating you for a mental condition may need to know what medications you are currently taking, because the medications may affect what other medications may be prescribed to you. We may also share Health Information about you with other **non-UC San Diego** providers.

For Payment. We may use and disclose Health Information about you so that the treatment and services you receive at UC San Diego CAPS or from other entities, such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about therapy you received at UC San Diego CAPS so your health plan will pay us or reimburse you for the therapy. We may also tell your health plan about a proposed treatment to determine whether your plan will pay for the treatment.

For Health Care Operations. We may use and disclose Health Information about you for our business operations. For example, your Health Information may be used to review the quality and safety of our services, or for business planning, management and administrative services. We may contact you about alternative treatment options for you or about other benefits or services we provide. We may also use and disclose your health information to an outside company that performs services for us such as accreditation, legal, computer or auditing services. These outside companies are called "business associates" and are required by law to keep your Health Information confidential. We may also disclose information to doctors, nurses, technicians, medical and other trainees, and other health system personnel for performance improvement and educational purposes.

Appointment Reminders. We may contact you to remind you that you have an appointment at UC San Diego CAPS.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical care, e.g., a friend, family member, personal representative, or any individual you identify. We may also give information to someone who helps pay for your care. We may also tell your family or friends about your general condition and that you are in the hospital.

Disaster Relief Efforts. We may disclose Health Information about you to an entity assisting in a disaster relief effort so that others can be notified about your condition, status and location.

Research. The University of California is a research institution. We may disclose Health Information about you for research purposes, subject to the confidentiality provisions of state and federal law. All research projects involving patients or the information about living patients conducted by the University of California must be approved through a special review process to protect patient safety, welfare and confidentiality.

In addition to disclosing Health Information for research, researchers may contact patients regarding their interest in participating in certain research studies. Researchers may only contact you if they have been given approval to do so by the special review process. You will only become a part of one of these research projects if you agree to do so and sign a specific permission form called an Authorization. When approved through a special review process, other studies may be performed using your Health Information without requiring your authorization. These studies will not affect your treatment or welfare, and your Health Information will continue to be protected.

As Required By Law. We will disclose Health Information about you when required to do so by federal or state law.

To Prevent a Serious Threat to Health or Safety. We may use and disclose Health Information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Military and Veterans. If you are or were a member of the armed forces, we may release Health Information about you to military command authorities as authorized or required by law.

Workers' Compensation. We may use or disclose Health Information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

Abuse and Neglect Reporting. We may disclose your Health Information to a government authority that is permitted by law to receive reports of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Proceedings. We may disclose Health Information to courts, attorneys and court employees in the course of conservatorship, writs and certain other judicial or administrative proceedings. We may also disclose Health Information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release Health Information:

- To identify or locate a suspect, fugitive, material witness, certain escapees, or missing person;
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death suspected to be the result of criminal conduct;
- About criminal conduct at UC San Diego; and
- In case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death.

National Security and Intelligence Activities. As required by law, we may disclose Health Information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. As required by law, we may disclose Health Information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

OTHER USES AND DISCLOSUERS OF HEALTH INFORMATION

Other uses and disclosures of Health Information not covered by this Notice will be made only with your written authorization. If you authorize us to use or disclose your Health Information, you may revoke that authorization, in writing, at any time. However, the revocation will not be effective for information that we have already used and disclosed in reliance on the authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Your Health Information is the property of UC San Diego CAPS. You have the following rights regarding the Health Information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or receive a copy of your Health Information. If we have the information in electronic format then you have the right to get your Health Information in electronic format if it is possible for us to do so. If not we will work with you to agree on a way for you to get the information electronically or as a paper copy.

To inspect and/or to receive a copy of your Health Information, you must submit your request in writing to Counseling and Psychological Services, UC San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0304. If you request a copy of the information, there is a fee for these services.

We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to Health Information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by UC San Diego CAPS will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment or Addendum. If you feel that Health Information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or for UC San Diego CAPS.

Amendment. To request an amendment, your request must be made in writing and submitted to Counseling and Psychological Services, UC San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0304. You must be specific about the information that you believe to be incorrect or incomplete and you must provide a reason that support the request.

We may deny your request for an amendment if it is not in writing, we cannot determine from the request the information you are asking to be changed or corrected or your request does not include a reason to support the change or addition. In addition, we may deny your request if you ask us to amend information that:

- Was not created by UC San Diego CAPS;
- Is not part of the Health Information kept by or for UC San Diego CAPS;
- Is not part of the information which you would be permitted to inspect and copy; or
- UC San Diego CAPS believes to be accurate and complete.

Addendum. To submit an addendum, the addendum must be made in writing and submitted to Counseling and Psychological Services, UC San Diego , 9500 Gilman Drive, La Jolla, CA 92093-0304. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your Health Information.

To request this accounting of disclosures, you must submit your request in writing to Counseling and Psychological Services, UC San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0304. Your request must state a time period that may not be longer than the six previous years. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

To request a restriction, you must make your request in writing to Counseling and Psychological Services, UC San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0304. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. *We are not required to agree to your request* except in the limited circumstance described below. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency care.

We are required to agree to a request not to share your information with your health plan if the following conditions are met:

1. We are not otherwise required by law to share the information
2. The information would be shared with your insurance company for payment purposes;
3. You pay the entire amount due for the health care item or service out of your own pocket or someone else pays the entire amount for you.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your Health Information in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail.

To request confidential medical communications, you must make your request in writing to Counseling and Psychological Services, UC San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0304.We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Copies of this Notice are available throughout UC San Diego CAPS, or you may obtain a copy at our website, http://caps.ucsd.edu. Right to be Notified of a Breach. You have the right to be notified if we or one of our Business Associates discovers a breach of unsecured Health information about you.

CHANGES TO SAN DIEGO HEALTH SYSTEM'S PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change the UC San Diego CAPS privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at UC San Diego CAPS. In addition, at any time you may request a copy of the current Notice in effect.

QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact the HIPAA Privacy Officer at Counseling and Psychological Services, UC San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0304; (858) 534-3755.

If you believe your privacy rights have been violated, you may file a complaint with UC San Diego CAPS or with the Secretary of the Department of Health and Human Services, Office for Civil Rights. To file a written complaint, contact: Counseling and Psychological Services, UC San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0304. You will not be penalized for filing a complaint.

OFFICE COPY

UNIVERSITY OF CALIFORNIA, SAN DIEGO
COUNSELING AND PSYCHOLOGICAL SERVICES
9500 Gilman Drive MC 0304
La Jolla, CA 92093-0304
(858) 534-3755/FAX (858) 534-2628

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

The Counseling and Psychological Services Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice are available by accessing our website at **http://psychservices.ucsd.edu** and may be obtained at our Central Office at 190 Galbraith Hall.

I acknowledge that I have received the Notice of Privacy Practices.

______________________________________ ________________________
Signature of Client or Client's Representative *Date*

______________________________________ ________________________
Print Name *Student ID*

Interpreter (if applicable) ______________________________ *Relationship to Client* ___________________

WRITTEN ACKNOWLEDGMENT NOT OBTAINED

Please document your efforts to obtain acknowledgment and reason it was not obtained.

- ☐ Notice of Privacy Practices Given – Client Unable to Sign
- ☐ Notice of Privacy Practices Given – Client Declined to Sign
- ☐ Notice of Privacy Practices and Acknowledgment Mailed to Client
- ☐ Other Reason Client Did Not Sign ____

______________________________________ ________________________
Signature of PCS Representative *Date*

____
Print Name