Psychological Services
Student Health and Wellness Services
Santiago Canyon College

COUNSELING CONTRACT

DEPOSIT PROCEDURE
A $5 deposit is required for psychological counseling. This deposit is also required if there are no appointments available and you are placed on a waiting list. Your deposit will be held until your sessions have been completed for the semester. Please understand it is your responsibility to pick up the deposit before the last week of the semester or it will not be refunded.

CANCELLED/MISSED APPOINTMENTS
Treatment consistency is an important part of the therapeutic process. If I choose to cancel my appointment, I risk loosing my appointment time with the therapist. If an appointment is missed without 24 hour prior notice to the Student Health and Wellness Services (714-628-4773), my appointment deposit will be forfeited. Subsequent appointments will require incremental increases in deposit for missed appointments.

If you are providing care to a child, you are responsible to make your own childcare arrangements. If you present for a therapy appointment with a minor child it is considered a missed appointment.

CONFIDENTIALITY
All information will be held in strict confidence. I will authorize release of information with my signature, or in these specific disclosures as required by law:

1. I present a physical danger to myself
2. I present a danger to others
3. Child/Elder/Dependant adult abuse or neglect are suspected

NECESSARY INFORMATION
I must disclose all previous counseling/psychological services and hospitalization(s) to enable the Student Health and Wellness Services to provide adequate standard of care. SCC Psychological Services typically sees students who are appropriate for brief therapy, limited crisis intervention, and those in need of outside referrals.

TREATMENT PROVIDER
All counseling services are provided by licensed clinical psychologists and doctoral level psychology interns under the direct supervision of a licensed psychologist.

CONSENT FOR TREATMENT
I understand the above and authorize psychological treatment and/or diagnostic testing to occur during the course of my care as advisable. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

I have read and acknowledge responsibility for appointment cancellation policies and the counseling contract established by the Student Health and Wellness Services.

__________________________  __________________ _______ __________
Name Printed                      Student Signature                   Date

__________________________  __________
Witness                              Date