

Counseling Center Consent Form

The Counseling Center provides free services to all Lisle campus undergraduate and graduate students. The expectation of the client is that you will actively listen, respond honestly, share concerns you may have regarding your counseling sessions, and consistently provide feedback to your counselor. An Individual session is scheduled for 50 minutes. A few highlights – please initial

_____ You will be required to be on time for your appointment. Should you be unable to keep your appointment, please notify the Counseling Center at least 24 hours in advance by calling (630) 829-1800.

_____ You may leave a voicemail for your counselor by calling (630) 829-1800. A counselor may need to reschedule your appointment in an emergency or if they find it necessary to be away from the Counseling Center.

The counselor will respond to you within 24 business hours. If you have an after-hour emergency, please dial #911, DuPage County Crisis Line at (630) 627-1700 or all Campus Police at (630) 829-6666. The Counseling Center provides short-term therapy to our students consisting of 6 or 7 sessions. To enable the Counseling Center to provide services to all students, we will review each case after the sixth individual session and make recommendations for further treatment or referrals at that time. If you want to end therapy, we ask you to discuss this with your counselor.

Confidentiality

Information shared in a counseling session is confidential and cannot be shared. The following are exceptions:
Please initial

_____ You may authorize the release of information in written form.

_____ If your counselor assesses you are a threat to yourself or someone else, the counselor will inform appropriate individuals for your protection and for the protection of others that may include the Dean of Students/Campus Safety.

_____ Cases involving child abuse or neglect.

_____ Your counselor may consult with another counseling professional to discuss your treatment and/or if you are a student athlete seeing an intern, your case will be shared with the counseling center coordinator. This will be done to ensure your best care and without identifying you by name. If there are reasonable grounds to believe you are a threat to yourself or others, we may require a clinical assessment performed at a hospital before you can return to school.

Consent for Treatment

I give my consent to meet with a counselor from the Benedictine University Counseling Center. I agree that my counselor will provide evaluation, treatment, or referral that we collaboratively agree upon. I understand my counseling records will be maintained by my counselor and that my counselor may discuss my case with other Counseling Center staff members. I understand all counseling services are confidential.

Student Signature and Date

Student Name and Student ID (Please Print)

Counselor's Signature