

## Confidential Personal Background Information

COMPLETE PRIOR TO FIRST SESSION AND DISCUSS ANY QUESTIONS WITH THE THERAPIST

TODAY'S DATE: \_\_\_\_\_

<b>First Name</b> _____ <b>Middle Initial</b> _____ <b>Last Name</b> _____ <b>Street Address</b> _____ <b>City, State, Zip Code</b> _____ <b>Client's Date of Birth</b> ____ / ____ / ____ month      day      year (____) ____ - ____ <b>Home: (Area Code) Phone Number</b> (____) ____ - ____ <b>Cellular: (Area Code) Phone Number</b>	<b>Occupation</b> _____ <b>Employer /School</b> _____ <b>Work / Campus Location</b> _____ (____) ____ - ____ <b>Work: (Area Code) Phone Number</b> <b>Insurance Information</b> _____ <b>Relationship to Covered Person</b> _____ <b>Social Security Number</b> _____ You have my permission to contact the person below in an emergency: _____ <b>Name</b> _____ <b>(Area Code) Phone Number</b> _____	
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### COMPLETE THE FOLLOWING INFORMATION FOR THE PERSON BEING SEEN TODAY

<b>EDUCATION</b> <input type="checkbox"/> Did Not Finish H.S. (Highest Grade _____) <input type="checkbox"/> H.S. Graduate / GED <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate <input type="checkbox"/> Advanced Degree <input type="checkbox"/> Technical / Vocational <input type="checkbox"/> Military	<b>MARITAL STATUS</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Living With Someone	<b>RACE</b> <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other	<b>GENDER</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>PERSON SEEKING ASSISTANCE</b> <input type="checkbox"/> Employee Only (EAP) <input type="checkbox"/> Employee & Family Member (EAP) <input type="checkbox"/> Family Member Only (EAP) <input type="checkbox"/> Student Only (SRS) <input type="checkbox"/> Student & Family Member (SRS)																								
<b>BEEEN TO COUNSELING BEFORE?</b> <input type="checkbox"/> No <input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three Times or More	<b>AWARE OF THE PROGRAM FROM</b> <input type="checkbox"/> Prior Participation <input type="checkbox"/> Newsletter Article <input type="checkbox"/> Poster / Brochure <input type="checkbox"/> Payroll Stuffer <input type="checkbox"/> Supervisor (Suggested) <input type="checkbox"/> Supervisor (Mandatory) <input type="checkbox"/> Union/Shop Steward (Suggested) <input type="checkbox"/> Coworker/Friend Suggested <input type="checkbox"/> Family Suggested <input type="checkbox"/> In-Service Training / Orientation <input type="checkbox"/> Home Mailing/School Communication <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Website	<b>WORK PERFORMANCE /ACADEMIC PROBLEMS (please check no more than 2)</b> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Attendance</td> <td><input type="checkbox"/> Theft</td> </tr> <tr> <td><input type="checkbox"/> Tardiness</td> <td><input type="checkbox"/> Missed Deadlines</td> </tr> <tr> <td><input type="checkbox"/> Safety Violations</td> <td><input type="checkbox"/> Leave of Absence from School</td> </tr> <tr> <td><input type="checkbox"/> Medical Leave</td> <td><input type="checkbox"/> Reduced Class Participation</td> </tr> <tr> <td><input type="checkbox"/> Mistakes</td> <td><input type="checkbox"/> School Personnel Relationships</td> </tr> <tr> <td><input type="checkbox"/> Forgetfulness</td> <td><input type="checkbox"/> DOT Violation</td> </tr> <tr> <td><input type="checkbox"/> Decreased Work Quality</td> <td><input type="checkbox"/> Violation of Alcohol or Drug Policy</td> </tr> <tr> <td><input type="checkbox"/> Decreased Work Quantity</td> <td><input type="checkbox"/> Worker's Comp Case</td> </tr> <tr> <td><input type="checkbox"/> Emotional Issues</td> <td><input type="checkbox"/> Co-worker or Student Relationships</td> </tr> <tr> <td><input type="checkbox"/> Health Issues</td> <td><input type="checkbox"/> Decreased Academic Performance</td> </tr> <tr> <td><input type="checkbox"/> Externship Issues</td> <td><input type="checkbox"/> Behavioral Misconduct</td> </tr> <tr> <td><input type="checkbox"/> No Problems</td> <td></td> </tr> </table>			<input type="checkbox"/> Attendance	<input type="checkbox"/> Theft	<input type="checkbox"/> Tardiness	<input type="checkbox"/> Missed Deadlines	<input type="checkbox"/> Safety Violations	<input type="checkbox"/> Leave of Absence from School	<input type="checkbox"/> Medical Leave	<input type="checkbox"/> Reduced Class Participation	<input type="checkbox"/> Mistakes	<input type="checkbox"/> School Personnel Relationships	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> DOT Violation	<input type="checkbox"/> Decreased Work Quality	<input type="checkbox"/> Violation of Alcohol or Drug Policy	<input type="checkbox"/> Decreased Work Quantity	<input type="checkbox"/> Worker's Comp Case	<input type="checkbox"/> Emotional Issues	<input type="checkbox"/> Co-worker or Student Relationships	<input type="checkbox"/> Health Issues	<input type="checkbox"/> Decreased Academic Performance	<input type="checkbox"/> Externship Issues	<input type="checkbox"/> Behavioral Misconduct	<input type="checkbox"/> No Problems	
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<b>REFERRED TO COUNSELING BY</b> <input type="checkbox"/> Supervisor (Mandatory) <input type="checkbox"/> Human Resources <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Self <input type="checkbox"/> Family/Friend <input type="checkbox"/> Union/Shop Steward (Suggested) <input type="checkbox"/> School Personnel																												

May we send a follow-up questionnaire to your home?    ☐ Yes    ☐ No

Primary Care Physician: \_\_\_\_\_  
 Psychiatrist: \_\_\_\_\_  
 Current Medication(s): \_\_\_\_\_

<b>Complete ONLY if person being seen is an EMPLOYEE or Employee Family Member</b> <b>WHAT BROUGHT YOU IN TODAY?</b> (please check no more than two) <input type="checkbox"/> Alcohol Use & Abuse <input type="checkbox"/> Alcohol Related (family member) <input type="checkbox"/> Dependent Care <input type="checkbox"/> Drug Related (family member) <input type="checkbox"/> Drug Use <input type="checkbox"/> Emotional <input type="checkbox"/> Family <input type="checkbox"/> Financial <input type="checkbox"/> Health Concerns <input type="checkbox"/> Issue Concerning Child <input type="checkbox"/> Legal <input type="checkbox"/> Marital / Relationship <input type="checkbox"/> Positive Drug Test <input type="checkbox"/> School Problem <input type="checkbox"/> Work Related	<b>Complete ONLY if person being seen is a STUDENT</b> <b>Program Enrolled In:</b> _____ <table style="width: 100%;"> <tr> <td style="width: 33%;"> <b>Enrollment Status</b>  <input type="checkbox"/> 1/4 Time  <input type="checkbox"/> 1/2 Time  <input type="checkbox"/> 3/4 Time  <input type="checkbox"/> Full Time         </td> <td style="width: 33%;"> <b>Length of Program</b>  <input type="checkbox"/> Less than 6 months  <input type="checkbox"/> 6 to 9 months  <input type="checkbox"/> 10 to 12 months         </td> <td style="width: 33%;"> <input type="checkbox"/> 13 to 18 months  <input type="checkbox"/> 19 to 24 months  <input type="checkbox"/> More than 24 months         </td> </tr> </table> <b>Program Completion</b> <input type="checkbox"/> < 1/4 <input type="checkbox"/> 1/4 up to 1/2 <input type="checkbox"/> 1/2 up to 3/4 <input type="checkbox"/> > 3/4 Enroll Date: ____ / ____ mm/yyyy      Grad Date: ____ / ____ mm/yyyy <b>WHAT BROUGHT YOU IN TODAY? (please check no more than two)</b> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Alcohol concern</td> <td><input type="checkbox"/> Financial</td> <td><input type="checkbox"/> Learning Problems</td> </tr> <tr> <td><input type="checkbox"/> Alcohol related (family)</td> <td><input type="checkbox"/> Food</td> <td><input type="checkbox"/> Positive Drug Test</td> </tr> <tr> <td><input type="checkbox"/> Current Domestic Violence</td> <td><input type="checkbox"/> Gambling problem</td> <td><input type="checkbox"/> Relationship Issues</td> </tr> <tr> <td><input type="checkbox"/> Dependent care</td> <td><input type="checkbox"/> Health concern</td> <td><input type="checkbox"/> School Related</td> </tr> <tr> <td><input type="checkbox"/> Drug use</td> <td><input type="checkbox"/> Housing</td> <td><input type="checkbox"/> Transportation</td> </tr> <tr> <td><input type="checkbox"/> Drug related (family)</td> <td><input type="checkbox"/> Issue Concerning a Child</td> <td><input type="checkbox"/> Utility Assistance</td> </tr> <tr> <td><input type="checkbox"/> Emotional</td> <td><input type="checkbox"/> Job Resources</td> <td><input type="checkbox"/> Work Related</td> </tr> <tr> <td><input type="checkbox"/> Family concern</td> <td><input type="checkbox"/> Legal</td> <td></td> </tr> </table>	<b>Enrollment Status</b> <input type="checkbox"/> 1/4 Time <input type="checkbox"/> 1/2 Time <input type="checkbox"/> 3/4 Time <input type="checkbox"/> Full Time	<b>Length of Program</b> <input type="checkbox"/> Less than 6 months <input type="checkbox"/> 6 to 9 months <input type="checkbox"/> 10 to 12 months	<input type="checkbox"/> 13 to 18 months <input type="checkbox"/> 19 to 24 months <input type="checkbox"/> More than 24 months	<input type="checkbox"/> Alcohol concern	<input type="checkbox"/> Financial	<input type="checkbox"/> Learning Problems	<input type="checkbox"/> Alcohol related (family)	<input type="checkbox"/> Food	<input type="checkbox"/> Positive Drug Test	<input type="checkbox"/> Current Domestic Violence	<input type="checkbox"/> Gambling problem	<input type="checkbox"/> Relationship Issues	<input type="checkbox"/> Dependent care	<input type="checkbox"/> Health concern	<input type="checkbox"/> School Related	<input type="checkbox"/> Drug use	<input type="checkbox"/> Housing	<input type="checkbox"/> Transportation	<input type="checkbox"/> Drug related (family)	<input type="checkbox"/> Issue Concerning a Child	<input type="checkbox"/> Utility Assistance	<input type="checkbox"/> Emotional	<input type="checkbox"/> Job Resources	<input type="checkbox"/> Work Related	<input type="checkbox"/> Family concern	<input type="checkbox"/> Legal	
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## Confidential Personal Background Information – Continued

### COMPLETE THE FOLLOWING INFORMATION FOR THE PERSON BEING SEEN TODAY

#### HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE LAST SIX MONTHS? (CHECK ALL THAT APPLY)

- |   |  |
|---|--|
| <input type="checkbox"/> Death of friend or family member<br><input type="checkbox"/> Major legal difficulties<br><input type="checkbox"/> Accused of crime / victim of crime<br><input type="checkbox"/> Personal injury, illness or accident<br><input type="checkbox"/> Problem with friend/family member<br><input type="checkbox"/> Abortion<br><input type="checkbox"/> Sexual harassment<br><input type="checkbox"/> Major change in financial status<br><input type="checkbox"/> Major change in employment status<br><input type="checkbox"/> Serious school-related problem | <input type="checkbox"/> New responsibility for elder parents<br><input type="checkbox"/> DWI / DUI<br><input type="checkbox"/> Recent birth of child<br><input type="checkbox"/> Marriage<br><input type="checkbox"/> Family injury, illness, or accident<br><input type="checkbox"/> Miscarriage<br><input type="checkbox"/> Sexual abuse, rape<br><input type="checkbox"/> Major geographic relocation<br><input type="checkbox"/> Serious job-related problems<br><input type="checkbox"/> Change in close personal relationship (divorce, separation, break-up) |
|---|--|

#### HAVE YOU USED ANY OF THE FOLLOWING SUBSTANCES? (CHECK ALL THAT APPLY)

	Ever Used? ( circle )	Currently Use (✓)	Last Used (Date)	Average Times Used	Average Use per Day / Week / Month
Anti-Depressants	Y / N				D / W / M
Anti-Anxiety / Sedatives	Y / N				D / W / M
Anti-Convulsants	Y / N				D / W / M
Alcohol	Y / N				D / W / M
Marijuana / Hashish	Y / N				D / W / M
Cocaine / Crack	Y / N				D / W / M
Narcotics / Heroin	Y / N				D / W / M
Hallucinogens / PCP LSD	Y / N				D / W / M
Amphetamines / Speed	Y / N				D / W / M
Barbiturates / Tranquilizers	Y / N				D / W / M
Inhalants	Y / N				D / W / M
Diet Pills	Y / N				D / W / M
Other: _____	Y / N				D / W / M

Have you ever received help for an emotional, drug, or alcohol problem? Y / N

If Yes, specify date and type of treatment: \_\_\_\_\_

#### 1. During the past month, how much of the time were you a happy person? (Circle your answer)

All of the time      Most of the time      A good bit of the time      Some of the time      A little of the time      None of the time  
 1                      2                      3                      4                      5                      6

#### 2. How much of the time, during the past month, have you felt calm and peaceful?

All of the time      Most of the time      A good bit of the time      Some of the time      A little of the time      None of the time  
 1                      2                      3                      4                      5                      6

#### 3. How much of the time, during the past month, have you been a very nervous person?

All of the time      Most of the time      A good bit of the time      Some of the time      A little of the time      None of the time  
 1                      2                      3                      4                      5                      6

#### 4. How much of the time, during the past month, have you felt downhearted and blue?

All of the time      Most of the time      A good bit of the time      Some of the time      A little of the time      None of the time  
 1                      2                      3                      4                      5                      6

#### 5. How much of the time, during the past month, did you feel so down in the dumps that nothing could cheer you up?

Always      Very often      Fairly often      Sometimes      Almost never      Never  
 1              2              3              4              5              6

Please complete if you or the person being seen are 16 years old or older.

#### Based on your personal experience, how would you RATE THE CHANCES that you might find yourself *using alcohol or drugs* excessively in the following circumstances? (Circle your answer)

	Extremely High	High	Moderate	Low	Extremely Low	N/A
When I'm at a party, similar other get-together	5	4	3	2	1	0
When I'm at a concert or other public event	5	4	3	2	1	0
When I'm celebrating something important to me	5	4	3	2	1	0
When I've had a fight with someone close to me	5	4	3	2	1	0
When I'm feeling sad, depressed or discouraged	5	4	3	2	1	0
When I'm angry with myself or someone else	5	4	3	2	1	0
When I'm with my lover	5	4	3	2	1	0
When I'm on a date	5	4	3	2	1	0
Before having sex	5	4	3	2	1	0



## 40 Question Survey

**INSTRUCTIONS:** READ EACH ITEM BELOW CAREFULLY AND DECIDE *HOW MUCH* YOU HAVE EXPERIENCED EACH SYMPTOM *IN THE LAST MONTH*. **CIRCLE** THE APPROPRIATE RESPONSE.

0= Not at all    1= A little bit    2= Moderately    3= Quite a bit    4= Extremely

1. Headache	0	1	2	3	4
2. Nervousness or shakiness inside	0	1	2	3	4
3. Feeling critical of others	0	1	2	3	4
4. Trouble remembering things at work	0	1	2	3	4
5. Feeling easily annoyed or irritated	0	1	2	3	4
6. Feeling low in energy or slowed down	0	1	2	3	4
7. Feeling that most people can not be trusted	0	1	2	3	4
8. Poor appetite	0	1	2	3	4
9. Crying easily	0	1	2	3	4
10. Temper outbursts that you could not control	0	1	2	3	4
11. Blaming yourself for things	0	1	2	3	4
12. Feeling blocked in getting things done	0	1	2	3	4
13. Feeling lonely	0	1	2	3	4
14. Worrying too much about things	0	1	2	3	4
15. Feeling no interest in things	0	1	2	3	4
16. Feeling fearful	0	1	2	3	4
17. Your feelings being easily hurt	0	1	2	3	4
18. Feeling others do not understand you or are unsympathetic	0	1	2	3	4
19. Feeling that people are unfriendly or dislike you	0	1	2	3	4
20. Heart pounding or racing	0	1	2	3	4
21. Feeling inferior to others	0	1	2	3	4
22. Drinking more alcohol than usual	0	1	2	3	4
23. Trouble falling asleep	0	1	2	3	4
24. Having to check and double-check what you do	0	1	2	3	4
25. Difficulty making decisions	0	1	2	3	4
26. Your mind going blank	0	1	2	3	4
27. Trouble concentrating at work	0	1	2	3	4
28. Overeating	0	1	2	3	4
29. Sleep that is restless or disturbed	0	1	2	3	4
30. Difficulty getting the job done	0	1	2	3	4
31. Having urges to break or smash things	0	1	2	3	4
32. Feeling very self-conscious with others	0	1	2	3	4
33. Others not giving you proper credit for your achievements	0	1	2	3	4
34. Shouting or throwing things	0	1	2	3	4
35. Feeling pushed to get things done	0	1	2	3	4
36. Thoughts of ending your life	0	1	2	3	4
37. Never feeling close to other persons	0	1	2	3	4
38. Feelings of guilt	0	1	2	3	4
39. Needing a medication or using drugs more	0	1	2	3	4
40. Having problems with co-workers	0	1	2	3	4

**STATEMENT OF SERVICES**

**STUDENT RESOURCE SERVICES (SRS)**

**VOLUNTARY PARTICIPATION:** *Student Resource Services, LLC* is a private consulting firm retained by your college to assist its students. Student Resource Services are provided at no cost to you. The school has already paid the fee. Among other services, this program provides a number of sessions to assess any problems and help you take action to improve or resolve any difficulties. The number of sessions is a decision left up to your counselor. If services are needed beyond what the SRS can provide, for example, a doctor or on-going care, the counselor will direct you to the proper resource for that care. It is then your responsibility to pay for services provided by any of these sources. Insurance coverage or other financial assistance may be applicable and it is our intent to help you clarify this.

The decision to receive student resource services is strictly voluntary even when referred to the program by faculty or administration staff. *It is essential you keep your appointments in order for us to provide consistent and effective services. In the event you cannot attend your session, please call us as soon as you become aware of this.* Your call allows us to offer your time to others and to provide timelier scheduling of appointments for all our clients. *If you fail to cancel within twenty four hours of an appointment, or do not keep the appointment, it may be counted as one of your SRS sessions.*

**CONFIDENTIALITY:** All case records will be held in the strictest confidence and are the property of Student Resource Services, LLC. Upon completion of services, all documentation pertaining to you will be stored at *Student Resource Services* headquarters. Information contained in the case record will not be released to any requesting party without the individual's written consent, except under a court order compelling disclosure, or where life or safety are seriously threatened, including at school, or as required by law. If you are formally referred for brief counseling services, called an administrative referral, then we will tell the referring school official whether you attended scheduled appointments, and if you are following the action plan established by your counselor. We may also inform of any specific risks to school property or staff, such as risk of violence. *(See our Notice of Privacy Practices for more details.)*

**QUALITY ASSURANCE:** Your SRS counselor receives assistance and guidance from the clinical management staff of People Resources, Inc. to make sure you receive the very best assistance possible. Your services will receive this ongoing review by the Vice President, Clinical Services or designee. This review is for the specific purpose of assuring you receive quality service.

I, \_\_\_\_\_  
*Client's Name (please print)*

have read this **Statement of Services** and understand its content. I have also received a copy of the **Student Resource Services, LLC Notice of Privacy Practices**, which explains all my privacy rights. I understand I can call Student Resource Services at 1.866.640.4777 if I have any questions about the Notice or want to use any of my privacy rights.

\_\_\_\_\_  
Client's Printed Name

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



**Student Resource Services, LLC**  
***Revised Notice of Privacy Practices for the***  
***Student Resource Services (SRS)***  
**Effective Date: March 1, 2012**

**This Notice describes how confidential information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Student Resource Services, LLC is dedicated to protecting all confidential information we collect and use in providing services. We follow all requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Federal Confidentiality Law 42 CFR, Part 2; and the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of the 2009 American Recovery and Reinvestment Act. *If you have questions, want to use your privacy rights or make a complaint, contact our **Privacy Officer** at Student Resource Services, LLC, 9666 Olive Blvd , Suite 705, St. Louis, MO 63132; 314-400-9696 or 866-640-4777.*

**I. How Student Resource Services May Use or Disclose Your Confidential Information**

Student Resource Services collects personal and health information from you and we store it in our confidential databases and sometimes in paper records. Student Resource Services uses and discloses your confidential information for the following purposes:

1. SRS Services. We assist students in finding resources, meeting needs and solving problems at home, school and at work. Our services include *web-based* information and referral services; *telephone-based* services such as confidential conversation with a Service Specialist,\* individualized telephone coaching, and referrals for health care or community services; brief, *in-person counseling* services; and evaluation and services provided if you are formally referred by your school, often called a *formal referral*. These services are free to you. We also provide training on accessing our services and improving your personal potential, such as stress management training.

In order to provide, pay for and manage these services, we collect personal information such as names, addresses, social security numbers and information you give us concerning issues and needs for which you would like our help. For example, if you would like to have brief counseling services, we will give your Service Specialist enough of your confidential information so the services can be provided. Another example is our quality review of some of our client records in order to see that services are properly provided. In all situations, we maintain our highest standards for protecting confidentiality.

Your school does NOT receive any confidential information about the services you seek or use, with one exception. If you are formally referred for brief counseling services, called a *formal referral*, then we will tell the referring official whether you called us, and with your signed release, dates and times of appointments, whether you kept scheduled appointments, and if you are following the action plan established by your Service Specialist. We may also inform of any specific, serious risks to school personnel or property, such as risk of violence. In some cases we may share anticipated time off school.

2. Other Possible Disclosures

Notification and communication with family. We may disclose your confidential information to a family member, your personal representative or another person legally responsible for your care

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\* A Service Specialist is a licensed counselor or certified Employee Assistance Professional who has been specially trained to provide SRS services. The Specialist may be a staff member or network affiliate.

*only with your express permission.* In an emergency when there is serious threat of harm to you or others, we may communicate with your family or others to ensure the safety of all involved.

Required by law or regulation. As required by law or regulation, we may disclose your confidential information. Examples include possible child abuse or domestic violence, or a serious possibility that you or others could be hurt or hurt someone else. We may also be required to disclose your private information to government health agencies for audits, investigations, inspections, licensure and other proceedings; to law enforcement officials for official business; to comply with a court order or subpoena; to prevent or lessen a serious threat to the health or safety of an individual or the general public; to comply with workers' compensation laws; for military, national security, prisoner or government benefits purposes; and/or to provide appointment reminders or give you information about our other services available to you.

*Except as detailed above, no other information is shared without your written permission, which must include your name, information to be disclosed and to whom, and time limit for sharing the information. You may revoke your authorization in writing at any time.*

## **II. Your Confidential Personal and Health Information Rights**

*You have the right to:*

- Inspect and copy your personal and health information, with the exception of a Service Specialist's personal psychotherapy notes. *We require your written request in advance and proof of your identity before we share the information.* You have the right to receive your health information through reasonable alternative means or at an alternative location. You have the right to request either a hard copy or an electronic copy of your records.
- Request that we make changes to your confidential information. We will review your request and may or may not make the change. If we deny your request, we will provide you with information about our denial and how you can disagree with our denial.
- Receive a list of any disclosures we have made of your personal information, except that we do not have to account for the disclosures needed for treatment, payment, operations or for military, national security, prisoner or government benefits purposes.
- Request restrictions on certain uses and disclosures of your personal and health information. People Resources is not required to agree to the restriction that you request. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket.
- Receive a paper copy of this Notice. We may ask you to sign your receipt of the copy.

## **III. Changes to this Notice & Making Complaints**

Student Resource Services reserves the right to amend or change this Notice at any time and to make any changes effective for all information that we maintain, including information already created or received. Until any changes are made, we are required by law to comply with this Notice. If we revise our Notice, we will put it on our web-site, [StudentLifeTools.com](http://StudentLifeTools.com), and provide written copies to our callers receiving services.

*Complaints about this Notice or our handling of your confidential information can be directed to our Privacy Officer.* If you are not satisfied with the manner in which we handle a complaint, you may submit a formal complaint to the Department of Health and Human Services, Office of Civil Rights.