



**Academic & Staff Assistance Program**

University of California, Santa Barbara  
Academic & Staff Assistance Program (ASAP)  
Intake Information

**Preferred Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Given Name:** \_\_\_\_\_ **Department & Job Title:** \_\_\_\_\_

**Role at UCSB** (please circle one):

Academic Personnel, Faculty, Staff, Post Doc, Family Member, Other: \_\_\_\_\_

**Referred by/how you heard about ASAP:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Gender Identity:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Relationship status:** \_\_\_\_\_

**Emergency Contact:**

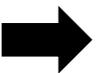
Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Reason for today's visit:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





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## Client Confidential Communications & Social Network Policy

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that **Clinicians and Administrative staff in ASAP** communicate clinical information to you in confidence by a particular method or certain locations.

ASAP staff do not accept friend requests from current or former clients on psychotherapy related profiles on social networking sites due to the fact that these sites can compromise client’s confidentiality and privacy. For the same reason, ASAP requests that clients do not communicate with ASAP clinicians via any interactive or social networking websites. In order to protect the privacy and confidentiality of your information, please complete the following which tells me how you would like to be contacted.

**I wish to be contacted in the following manner (Initial all that apply):**

### Phone Communications

Please, contact me at, phone number \_\_\_\_\_.

It is okay to leave me a message with your name and call-back number on my voicemail.

It is okay to leave me a message with appointment scheduling information on my voicemail.

### Written Communication

I **do not** want to communicate by E-mail regarding ASAP related information.

It is okay to communicate with me via E-mail. Preferred email \_\_\_\_\_

**Clinicians in ASAP** will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form.

**By your signature below, you agree to be communicated in the above manner.**

Client Signature \_\_\_\_\_

Client Name \_\_\_\_\_

Date \_\_\_\_\_





Academic & Staff Assistance Program  
**INFORMED CONSENT FOR ASAP SERVICES**

**WELCOME**

Welcome to the UCSB Academic & Staff Assistance Program (ASAP). **ASAP is a professional service offering consultation, brief assessment, short term counseling, and community referrals by skilled mental health Clinicians for UCSB academic personnel, faculty, staff, and eligible family members.** Your appointment today is a unique opportunity to talk with an ASAP clinician who will assist you in identifying and clarifying your goals and options. In order to serve you better, below is important information about the services you can receive at ASAP. Please read this *Informed Consent for ASAP Services* and discuss any questions or concerns you have with your clinician.

**CONFIDENTIALITY**

ASAP complies with professional, legal, and ethical guidelines established by the American Psychological Association, the Board of Behavioral Sciences, and the State of California. All information about interactions with ASAP clinicians are confidential, except as noted below. Information about contacts with ASAP does not go into academic or personnel files.

**EXCEPTIONS TO CONFIDENTIALITY**

- To provide the best possible care, a clinician may discuss the content of counseling sessions with other clinical staff who will be held to the same standards of confidentiality.
- A counselor is legally required to report evidence that there is a clear and imminent danger of harm to the client and/or others.
- A counselor is legally required to report actual or suspected sexual abuse or physical neglect of minors, dependent adults, or the elderly.
- ASAP may be required, by court order or subpoena, to release information and/or require a clinician to testify in a court hearing.
- The client may give written consent to ASAP to release specific information to a designated person or agency.

**EMERGENCY SERVICES**

ASAP is open Monday through Friday from 8:00 a.m. to 5:00 p.m., and does not provide emergency services after hours. In an emergency you may try to reach your clinician but it is important to have an alternative plan. Inform your clinician in advance if you are aware of a pending crisis or significant stressors for which it would be appropriate to develop a crisis plan. Identify services that are available to you at all hours of the day. If you are having an emergency, you can always call 911 or head to the nearest emergency room.





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### ACKNOWLEDGEMENT

Your signature below indicates that you have read and understand the information provided in this *Informed Consent for ASAP Services*. If you have any questions or are unclear about anything in this form, please feel free to discuss with your clinician.

- I understand that my eligibility for participation is contingent upon my status as a UCSB employee or a family member living with a UCSB employee (i.e., a spouse/partner and/or children over 18 years of age).
- I understand that I am a full participant in this process and that the types of services and referrals I receive will be determined in consultation with ASAP staff and myself.
- I understand the nature and limits of confidentiality.
- I understand that ASAP does not provide emergency services. I understand it is my responsibility to develop a plan for how to obtain emergency care if it is needed.
- I understand that I may consult with the Manager of ASAP at any time if I have any concerns about any ASAP services that I have received.
- I understand that there is no cost for the services provided by ASAP staff. If referrals are made that are not fully covered by my benefits any such costs will be my responsibility.
- I have read and understand the *Informed Consent for ASAP Services* and have had the opportunity to discuss any questions that I have. I request and voluntarily consent to receive counseling services from ASAP. I understand that I may discontinue counseling services at any time.

### Telehealth Services

I understand that I have the option to use telehealth services, such as phone sessions. I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to individuals when they are located at a different site than the provider; and hereby consent to ASAP clinicians providing health care services to me via telehealth.

I understand that the laws that protect privacy and the confidentiality of behavioral health information also apply to telehealth. I understand that I must be physically in the state of California to comply with licensing laws that govern psychologists and will comply with the requirement in order to receive telehealth services.

I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting ASAP at 805-893-3318.





**Academic & Staff Assistance Program**

As long as this consent is in force (has not been revoked), ASAP may provide health care services to me via telehealth without the need for me to sign another consent form.

**I have read the *Informed Consent* for ASAP Services and agree to the limits and exceptions as stated.**

\_\_\_\_\_

Client Printed Name

\_\_\_\_\_

Client Signature

\_\_\_\_\_

Clinician/witness signature

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Date

\_\_\_\_\_

Date

**Acknowledgement of Receipt of Notice of Privacy Practice**

I, \_\_\_\_\_, have received a copy of this Office's Notice of Privacy Practices.

Client name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**It is your right to refuse to sign this document**

**For Office Use Only:**

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

\_\_\_\_\_ Client refused to sign.

\_\_\_\_\_ Communication barriers prohibited obtaining the acknowledgement.

\_\_\_\_\_ An emergency situation prevented this office from obtaining it.

\_\_\_\_\_ Others: \_\_\_\_\_