**Initial Mental Health Packet**
Revised 7.26.19

TEXAS TECH UNIVERSITY
Student Health Services

Name:

Date of Birth:

## Initial Mental Health Acknowledgment Statement

I, ________________________________________, understand that the mental healthcare provided through Student Health Services is restricted in the following ways.

_____ Care is provided through scheduled appointments when mental health services are available.

_____ Student Health Services does not offer 24-hour crisis intervention, weekend or holiday coverage or inpatient care. Emergency or Crisis evaluations and care will be referred to a local emergency room, the cost of which is not covered by the Texas Tech University Medical Service Fee and will be your responsibility.

_____ Referrals to Mental Health Services outside of Student Health Services is at the discretion of your provider and based on the severity of your illness or complications related to your illness. The cost of services outside of Student Health Services is not covered by your Texas Tech University Medical Service Fee and will be your responsibility.

_____ The number of appointments available is limited. We require you to be on time for your appointment. If you are unable to keep an appointment, please call the clinic to cancel your appointment 24 hours before your appointment. No show fees are charged if an appointment is not cancelled prior to the appointment time.

_____ Follow-up appointments are a very important part of your healthcare. Telephone refills on medications are given at the discretion of the provider and may be denied if you have not kept appointments.

_____ I understand that information I disclose to a provider at Student Health Services may be shared with other providers or staff within Student Health without my written consent if the information is considered relevant to the coordination and safety of my care.

____ I understand that the information I disclose is considered confidential and is subject to the same State and Federal Laws that govern all healthcare facilities.

____ I acknowledge that I am requesting the mental health services offered at Student Health Services voluntarily and of my own free will. I understand that I may choose to discontinue services at any time.

____ Medications are prescribed at the discretion of the provider and are intended for the use of the individual. Sharing of medications or selling medications is a criminal offense and may result in prescriptions no longer being refilled.

____ I understand that medications may cause unwanted side effects and it is important to inform my health care provider of side effects.

____ I understand that certain medications should not be taken during pregnancy. I understand that if I am pregnant or planning to become pregnancy in the near future, I should notify my healthcare provider immediately.

_________________________________________      ______________________________

Signature      Date