UNIVERSITY HEALTH SERVICES
UNIVERSITY OF WISCONSIN-MADISON
333 East Campus Mall
Madison, WI 53715-1381
http://www.uhs.wisc.edu

MR#_____
Name_____
BD_____Gender_____
ID#_____ Date_____

Couple/Partner Counseling Participation Agreement

Thank you for your interest in participating in couple/partner counseling at University Health Services – Mental Health Services (UHS-MHS). Some special circumstances and responsibilities unique to couple/partner work are outlined in this document.

Attendance
In couple work your relationship is the "client" so when one partner cannot attend a session, the appointment needs to be cancelled & rescheduled. Whenever scheduling or cancelling appointments please provide the names of both partners. As a protection of your privacy, schedulers will not automatically have access to your partner's identifying information.

Confidentiality
Each partner will be requested to complete surveys on the computer after checking in for a couple session. The surveys assist your counselor in assessing progress toward your goals as well as your personal well-being. This survey information will be reviewed by your counselor who may follow-up on critical items in the session with your partner present. A professional decision may be made to contact you individually by secure message or phone to determine safety and assess whether couple counseling is able to provide the level of support needed. Clinical documentation is kept separately for each partner.

Collaborative Care
If you receive services from a mental health provider in the community, UHS-MHS may request a release of information (ROI) to coordinate your care. It is your responsibility to promptly inform your counselor (1) of any change in your treatment, (e.g., medications, stopping individual therapy, or changing individual therapists) or (2) if you are anticipating or currently involved in any legal action which relates to your request for services. UHS-MHS is not able to participate in court assessments or legal proceedings, and can assist you in locating the appropriate community resources.

By signing this form I certify that (1) I have read this form, (2) I wish to participate in couple/partner counseling at UHS-MHS and (3) certify the following as accurate:

My Partner's name for couples counseling is:_____

If I am currently participating in mental health care or medication management outside of UHS I have told my MHS Counselor OR if I begin outside mental health treatment during the course of couples therapy, then I agree to promptly inform my UHS-MHS counselor. ☐ Yes ☐ No ☐N/A

☐ I have no current, pending or anticipated court or legal proceedings, and agree to promptly inform my UHS counselor regarding any change in this status.

☐ I consent to having my UHS survey information discussed with my partner present for the duration of couple/partner appointments.

_____ _____ _____
signature of participant printed name date

5-4-20