WELCOME!

Welcome to the NSU Center for Student Counseling and Well-Being (CSCW)! As a current full or part-time NSU student, you can participate, at no charge, in up to 10 individual (or couple/family) counseling sessions from the date of your first session. Your first appointment is a 60-minute assessment that will either help you manage your current circumstances, or it will be utilized to determine your treatment moving forward. If you are looking to continue medication management or want to meet with the psychiatrist for the first time, the appointments have a cost associated, however, insurance may cover most or all the cost. Please feel free to speak with our Office Manager to determine eligibility and fees. In addition, please note that if you arrive more than 10 minutes late for any appointment, the appointment slot will be considered forfeited and you may be asked to re-schedule.

You will receive a program brochure (upon arrival, via email, or download from website) that includes a brief description of our services, your Rights & Responsibilities, Health Care Advanced Directives, and the Grievance & Appeals procedure. If you desire to have a copy of the full program description, please ask the Health Information Specialist and one will be provided to you.

We hope that you will find us respectful of and sensitive to your religious beliefs, sexual orientation, ethnicity, and culture. We are committed to providing you with a safe and welcoming environment in which you can explore opportunities and possibilities for change. In addition, should you need to register to vote, you may receive information on the process from the Health Information Specialist at the Front Desk.

If you would like for to share your information with someone else, we'll be happy to do so, but only after a signed "Authorization to Release Information" (ROI) form is completed, explicitly giving us your permission.

To help our students get the most out of their time with us, all counselors and students who are counselors-in-training are required to consult with their supervisors and/or professional colleagues about their therapeutic work. Everyone who works at the CSCW and Henderson Behavioral Health is bound by rules of confidentiality.

All services at CSCW are voluntary, yet should the request for legally mandated services arise, referrals will be provided to you. If you require extended or specialized services than we're able to provide, we will also offer you appropriate referrals to on or off-campus professionals.

Hours of Operation**

Monday	8:30am – 6:00pm
Tuesday	8:30am – 8:00pm
Wednesday	8:30am – 8:00pm
Thursday	8:30am – 6:00pm
Friday	8:30am – 5:00pm

**Hours may vary during holidays and summer

It is important to us that we are providing you with the best possible service. To this end, you will be asked to fill out a short satisfaction survey when you conclude your services with us. We wish you the best in achieving your therapeutic goals.

AFTER HOURS ON-CALL COUNSELOR: 954-424-6911 www.nova.edu/studentcounseling

NSU Center for Student Counseling and Well-Being
3301 College Ave., SAB 3rd Floor, Davie, FL 33314
PHONE: (954) 424-6911 or (954) 262-7050 FAX: (954) 424-6916

Henderson Student Counseling Services

NSU Florida
CENTER FOR STUDENT COUNSELING AND WELL-BEING

Henderson Behavioral Health

MISSION STATEMENT

It is our mission to be the premier provider of accessible, cost effective, and quality behavioral healthcare services to the people of South Florida, in order to promote their mental health and well-being.

HENDERSON BEHAVIORAL HEALTH
STATEMENT OF VALUES/CODE OF ETHICS

In Pursuit of our Mission, we commit to upholding the following values in all our interactions with our customers and staff:

***INTEGRITY**
We lead by example, tolerating only honest and professional behavior;

***RESPECT**
We demonstrate regard for others in our actions and communications

***COMMITMENT**
We pledge our dedication to the achievement of our Mission, and our allegiance to the staff who pursue those goals inherent in our Mission;

***COMPASSION**
We care for those we serve by actively listening to their concerns, and supporting them in their pursuit of well-being;

***ACCOUNTABILITY**
We accept responsibility for our own actions, the tasks we are given, the resources to which we have access, and ultimately, to the individuals we serve;

***PROFESSIONALISM**
We establish and maintain ethical codes of behavior and conduct which are reflective of the quality of service our customers deserve and expect.

This orientation packet is designed to familiarize you with our services and can be utilized as a quick reference guide. Our staff is dedicated towards providing professional care to individuals in need.

We are proud to be your behavioral health provider!

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Counseling Agreement

As you will learn more about in the HIPAA Notice of Privacy Practices, which has been provided to you pursuant to federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI), the NSU Center for Student Counseling and Well-being, provided by Henderson Behavioral Health, will only use and disclose your PHI as permitted by law. The Notice explains HIPAA and its application to your personal health information in greater detail.

I hereby grant my permission to the professional staff of the NSU Center for Student Counseling and Well-being (CSCW) to provide counseling and/or prescribe medications that they consider necessary or advisable. I understand that I may amend or revoke this authorization at any time upon written notification.

I understand that the CSCW employs full-time staff counselors and, in addition, offers a training program for students who are counselors-in-training, and their supervisors will have access to records of their clients as necessary for their training and the CSCW's health care operations. The counselors-in-training are under appropriate supervision of counselors, psychiatrists, and/or psychologist (as applicable). All staff counselors, counselors-in-training, and the supervisors will maintain confidentiality in accordance with state and federal privacy regulations.

I understand that the information I share with the CSCW professional staff and counselors-in-training is confidential and unless mandated by law or otherwise permitted by law (for example in certain emergency situations), will not be revealed to anyone without my written permission.

I understand that the CSCW may disclose my protected health information as necessary to carry out treatment, payment, and healthcare operations of the CSCW. This constitutes a written waiver under Florida law. For example, if my service is reimbursable by a third-party payor, I am authorizing Henderson Behavioral Health to submit necessary information in order to receive payment for the services.

I understand that Florida law mandates the CSCW professional staff to honor court orders (F.S. 90.503) and to report knowledge of or instances of suspected abuse or neglect (F.S. 415.504) of children, elders, or disabled persons. In addition, I understand that per Florida Statute (Chapter 490.0147 Confidentiality and Privileged Communications) Henderson Behavioral Health professional staff may disclose confidential information to certain individuals identified in the law when there is clear and immediate probability of physical harm or risk to me or other individuals or to society.

Furthermore, Florida Statute (F.S. 456.059) states, a psychiatrist may disclose patient communications where:

- The patient is engaged in a treatment relationship with the psychiatrist;
- Such patient has made an actual threat to physically harm an identifiable victim or victims; and

- The treating psychiatrist makes a clinical judgment that the patient has the apparent capability to commit such an act and that is more likely than not that in the near future the patient will carry out that threat.

Under precedence, the treating psychiatrist may disclose patient communications to the extent necessary to warn any potential victim or communicate the threat to a law enforcement agency.

I understand that the first session is an Assessment appointment that will help me manage my current circumstances or be utilized towards determination of my continuing treatment. I understand that the plan for discharge is initiated during the assessment session with the counselor. I understand that my length of stay and the possible options will be presented to me including but not limited to the use of allowable sessions, referrals to community service providers, or re-engagement if services are discontinued for any reason prior to the full utilization of allowable sessions. I am aware that my plan for discharge will be addressed periodically during the course of services, ensuring that I am aware of options available to me during and after treatment with Henderson Student Counseling Services.

I agree to notify the NSU Center for Student Counseling and Well-being at least 24 hours in advance should I need to cancel an appointment, and I understand that if I fail to do so, my missed session will be counted as one of my annual allotted sessions.

I am aware that I have access to an on-call counselor after hours and the process has been explained to me.

This information will be reviewed and signed at the front desk prior to your appointment.

Henderson Student Counseling Services

NSU Florida
CENTER FOR STUDENT COUNSELING AND WELL-BEING

NOTICE OF PRIVACY PRACTICES

This Notice describes how your medical information may be used and/or disclosed, and how you may access this information.

Henderson Student Counseling Services (HSCS) has a legal responsibility to protect your medical information. Protected Health Information (PHI) is information about you that may identify you in that it relates to your past, present or future physical, mental health, condition, and/or related health care services; including demographic information.

Uses and/or Disclosures of Your PHI Without Your Authorization:

- **Treatment**
- **Payment**
- **Healthcare Operations**
- **Other Legally Mandated Uses and/or Disclosures**

Any Other Use or Disclosure of Your PHI Requires Your Written Authorization

YOUR RIGHTS

- **To request restrictions of the uses and/or disclosures of your PHI**
- **To request to receive confidential communications from HSCS by alternative means, or at an alternative location.**
- **To inspect and copy your PHI.**
- **To request amendment of your PHI.**
- **To receive an accounting of disclosures made by HSCS of your PHI.**
- **To obtain a paper copy of this complete Notice.**

You May Object to the Use and/or Disclosure of Your PHI. You also may complain about the privacy practices at HSCS. Please contact the Privacy Officer at: 954-777-1674.

You may also send a written complaint to the United State Secretary of the Department of Health and Human Services. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

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Student Name:_____

Medical Record:_____

Acknowledgement of Receipt of
HIPAA Notice of Privacy Practices

I acknowledge that I have received the attached HIPAA Notice of Privacy Practices.

_____	_____	_____
Signature of student or representative	Printed name	Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the student.

_____

_____

AFTER HOURS ON-CALL COUNSELOR: 954-424-6911 *www.nova.edu/studentcounseling*

The acknowledgment of the receipt of your Privacy Practices Notice was provided by you in the on-line registration portal

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CENTER FOR STUDENT COUNSELING AND WELL-BEING

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

I _____ **DOB:** _____ **SS#:** _____
Name of Student (PLEASE PRINT)

hereby give my permission to **Henderson Student Counseling Services** or to the entity listed below to release information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

To/From: Information here will be obtained from Portal Registration
Name and Address of Person(s), Agencies, Organization to which information is to be released/requested.

Purpose of this release/request: EMERGECNY CONTACT

I authorize release/request of information covering treatment dates of: All Treatment Dates

The type of information to be disclosed/requested is as follows:

To Be Released		To Be Requested	
_____	Treatment Plans	_____	Treatment Plans
_____	Progress Reports	_____	Progress Reports
_____	Health/Medical Records	_____	Health/Medical Records
_____	Education Reports	_____	Education Reports
_____	Discharge Summaries	_____	Discharge Summaries
_____	Psychological/Psychiatric Evaluations	_____	Psychological/Psychiatric Evaluations
_____	Social/Developmental History	_____	Social/Developmental History
X	Verbal Communication	X	Verbal Communication
X	Other-	X	Other

1) I agree to allow authorized personnel, from Henderson Student Counseling Services, to receive a copy of my medical record.
2) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Henderson Student Counseling Services.
3) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Henderson Student Counseling Services will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).
4) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Henderson Student Counseling Services.
5) I understand that Henderson Student Counseling Services will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire twelve months from the date of signing and is subject to revocation in writing at any time.

Release:

Student Signature _____ **Date** _____

Witness _____ **Date** _____

Request:

Student Signature _____ **Date** _____

Witness _____ **Date** _____

The approval for this Authorization was provided in the on-line registration portal.

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Henderson Student Counseling Services

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CENTER FOR STUDENT COUNSELING AND WELL-BEING

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

I _____ **DOB:** _____ **SS#:** _____
Name of Student (PLEASE PRINT)

hereby give my permission to **Henderson Student Counseling Services** or to the entity listed below to release information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

To/From: Nova Southeastern University
Name and Address of Person(s), Agencies, Organization to which information is to be released/requested.

Purpose of this release/request: Emergency Contact for Situations Involving Perceived Threat

I authorize release/request of information covering treatment dates of: All Treatment Dates

The type of information to be disclosed/requested is as follows:

To Be Released		To Be Requested	
_____	Treatment Plans	_____	Treatment Plans
_____	Progress Reports	_____	Progress Reports
_____	Health/Medical Records	_____	Health/Medical Records
_____	Education Reports	_____	Education Reports
_____	Discharge Summaries	_____	Discharge Summaries
_____	Psychological/Psychiatric Evaluations	_____	Psychological/Psychiatric Evaluations
_____	Social/Developmental History	_____	Social/Developmental History
X	Verbal Communication	X	Verbal Communication
X	Other-	X	Other

1) I agree to allow authorized personnel, from Henderson Student Counseling Services, to receive a copy of my medical record.
2) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Henderson Student Counseling Services.
3) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Henderson Student Counseling Services will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).
4) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Henderson Student Counseling Services.

I understand that Henderson Student Counseling Services will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire twelve months from the date of signing and is subject to revocation in writing at any time.

Release:

Student Signature _____ **Date** _____

Witness _____ **Date** _____

Request:

Student Signature _____ **Date** _____

Witness _____ **Date** _____

The approval for this Authorization was provided in the on-line registration portal.

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RIGHTS AND RESPONSIBILITIES OF INDIVIDUALS

Henderson Behavioral Health will protect and promote the rights of individuals to the fullest extent of the law. At all times, individuals will be treated with respect and dignity and will sensitivity to their cultural background, social, psychological, physical, and spiritual factors.

NON-DISCRIMINATION POLICY

No person shall, on the basis of race, color, religion, national origin, sex, age, socio-economic status, disability or handicap be excluded from the participation in, be denied the benefits of, or be subjected to unlawful discrimination under any program or activity receiving or benefiting from federal financial assistance and administered by the Department of Children and Family Services.
No person meeting our entrance criteria shall be denied access to services by Henderson Behavioral Health.
At all times, person served will be treated with respect and dignity and with sensitivity to their age, gender, socio-economic status, social supports, cultural orientation, psychological characteristics, sexual orientation, physical situation, and spiritual beliefs.

RIGHT OF INDIVIDUAL DIGNITY

Henderson Behavioral Health shall not exploit any person served, or require them to make public statements acknowledging gratitude to the agency or perform at public gatherings.
To be respected at all times.
To manage own financial affairs, to the fullest extent possible.
To be free from physical, psychological, or sexual abuse/harassment, neglect and physical punishment.
To be free from psychological abuse, including humiliating, threatening, or exploitive actions.
To be informed of crisis services available and procedures utilized by the facility, including voluntary and involuntary hospitalization procedures, and any seclusion or restraint policies.

RIGHT TO TREATMENT

To receive treatment in the least restrictive setting possible.
To be free of unnecessary drugs.
To decline to participate in research of any kind.
To participate/review the development and planning of services to be rendered. Individuals are encouraged to participate in the development of their treatment goals, objectives and discharge plans with the professional staff.

RIGHT TO BE FREE OF FINANCIAL ABUSE

To be assessed a fee for all services at Intake which is based on a standardized Sliding Fee Schedule according to the current Federal Poverty Guidelines AND the resources, insurances, and ability to pay.
To have the opportunity to a financial update annually to report any changes in financial and insurance status.
No person is refused services due to an inability to pay; however, refusal to pay agreed upon fees may result in services being re-scheduled or terminated.
There are auditing and adjustment procedures in place to ensure that only services received are billed to the appropriate parties/funders/insurances.

RIGHT TO QUALITY TREATMENT

To receive treatment that is skillfully, safely, and humanely administered.
To receive behavioral care services as are needed: medical, therapeutic, vocational, social, educational, and rehabilitative.
To choose providers of behavioral care services; to request a second opinion; or to request a transfer of providers.
To receive information on the expected results and side-effects of treatment and services.
To receive assistance for language interpretation, hearing impaired assistance and other special needs services when requested.

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RIGHT TO EXPRESS AND INFORMED CONSENT
To consent, or not consent, in writing, once informed, to treatment/services(s), or combination of services, and to release and/or obtain records, unless restricted by a Judge or in an emergency.
To be informed about the nature of the treatment, and treatment options to facilitate the individual's decision making.
To consent to, or not consent to, in writing, to any research conducted by Henderson Behavioral Health, including the right to terminate participation at any point in the research process; and the right to receive notice of all potential risks involved with the research process. All research conducted by Henderson Behavioral Health shall adhere to all government regulations, adhere to professional ethics, be pre-approved by the designated authority, and be sensitive to the cultural and ethnic background of all participants. Written consent to participate in research activities also includes the use, deposition and release of the data. To refuse or terminate services at any time by contacting assigned staff in person, by phone, and/or by letter or intent.

RIGHT TO COMMUNICATION AND ABUSE REPORTING
To communicate with persons of their choice.
To have access to a telephone at any time to report abuse or neglect (1-800-96-ABUSE).
To make complaints and receive timely responses.
To be informed of the Grievance Procedures should any complaints not be resolved appropriately, which includes documenting the investigative steps and the resolution of the person's grievance.

RIGHT TO PRIVACY
The facility space, furnishings, and telephone shall enable staff to provide appropriate services/supervision while respecting the privacy of individuals.

RIGHT TO CONFIDENTIALITY
The rights to confidentially in all matters pertaining to your course of treatment, including all written records, in accordance with all current governing statutes. All individuals have the right to receive a Privacy Notice as required by federal mandate.
To designate, if legally competent, who or which agencies shall receive or send us information about your treatment.
To know that only a court order, or an emergency situation, can result in information from, your clinical record being shared.
To have reasonable access to your records.
To have your record kept confidential.

RIGHT TO PETITION FOR A WRIT OF HABEAS CORPUS (Court Order)
To ask the cause and legality of your detention.
To ask the circuit court to order your release.

RIGHT TO DESIGNATE REPRESENTATIVES
To designate a person to receive notices if you are admitted to a hospital or residential program.
To access a guardian, conservator, self-help groups, and/or or advocacy services or legal advocates.

RESPONSIBILITIES OF INDIVIDUALS
As a person receiving services from Henderson Behavioral Health, you have the responsibility to:
1. To keep predetermined appointments.
2. To notify the center at least 24 hours in advance of canceling an appointment.
3. To participate in the development of treatment goals, objectives, and discharge plans.
4. To follow agreed upon treatment.
5. To maintain confidential information pertaining to group therapy members (when applicable)
6. To assume responsibility for payment of the assessed fee for services.
7. To inform staff of any changes of address, telephone number, medical insurance policies, or financial status.

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GRIEVANCE AND APPEAL PROCEDURE

- You have the right to file a **COMPLAINT** with any staff member regarding dissatisfaction with services or if you feel that your civil rights have been violated.

- If your compliant is not resolved to your satisfaction, OR if the problem is of a more serious nature, you may file a **GRIEVANCE**.

- To file a grievance, ask any staff member, OR contact the Recovery Support Specialist and/or Director of Services in this facility.

- You may request assistance or advocacy from entities within or outside of Henderson in processing the grievance.

- The staff member, Recovery Support Specialist and/or Director of Services with whom you have filed a grievance will work with you directly OR refer you to the appropriate person(s) to reach an agreement within two (2) weeks. An additional week may be required in some cases. At the end of this time the final results will be presented to you in writing.

- If the grievance is not resolved to your satisfaction. You may file an appeal by calling Henderson's Risk Management Coordinator (954.777.1612).

There will not be any retaliatory consequences regarding your treatment due to filing of a grievance

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HEALTH CARE ADVANCE DIRECTIVE

THE PATIENT'S RIGHT TO DECIDE

Making personal decisions to guarantee your healthcare choices

Introduction

Florida law grants every adult the right to make certain decisions about his or her medical treatment.* You have the right, under certain conditions, to decide whether to accept or reject medical treatment and other procedures that would prolong your life artificially. The law also ensures your rights and personal wishes are respected even if you are too sick to make your own decisions.

PREPARED BY THE OFFICE OF:

LICENSURE AND CERTIFICATION

& HEALTH CARE ADMINISTRATION

The following can be used to direct your future behavioral health care needs.

- The person you choose to be your health care surrogate must be a competent adult whose civil rights have not been taken away.
- The person you choose should **not** be a mental health professional, an employee of a facility that might provide services to you, an employee of the Department of Children & Family Services or a member of the Local Advocacy Council.
- Make sure your surrogate understands your wishes and is willing to accept the responsibility. Your surrogate (and a back-up alternate surrogate if you wish) should sign the form.
- Have copies made and give them to your surrogate, your case manager, your doctor, the hospital or crisis unit at which you are most likely be treated, your family and anyone else who might be involved in your care.
- The document should be available quickly if you need it. If you travel, be sure to take a copy with you.

3301 College Ave., SAB 3rd Floor,
Davie, FL 33314
Phone (954) 424 - 6911 NSU
Phone (954) 424 - 6916 BC
Phone (954) 424 – 6868 UM

Fax (954) 424 – 6915

Henderson Behavioral Health

FAQs About Advance Directives

On what laws are Advance Directives based?
Two main statutes guide the Advance Directives. At the federal level there is the Patient Self-Determination Act and at the state level, Florida's Health Care Advance Directive Act (Florida Statute Chapter 765). These statutes outline the guidelines for directives.

Why is it important for me to complete Advance Directives?
There may be times whether because of an accident, injury or illness, you may not be able to make sound decisions about your health care. However, decisions still need to be made regarding your treatment and care; directives outline who can legally speak on your behalf and see that your wishes are carried out.

Who can complete a directive?
Any person who is 18-years of age and older, as well an emancipated minor, can have Advance Directives.

When are they valid?
You will need two witnesses present when you sign your directives. Only one can be a spouse, family member or relative; your health care surrogate cannot be a witness. These documents do not need to be notarized to be legal, though some prefer to have them notarized along with any other legal documents, such as a will.

Your advance directive will not take effect unless a physician decides that you are not competent to make your own treatment decisions.

If you are in a psychiatric facility, you will have an attorney appointed to represent your interests and a hearing in front of a judge or hearing master.

A health care surrogate is not authorized to consent to treatment for a person on voluntary status.

HEALTH CARE ADVANCE DIRECTIVE

THE PATIENT'S RIGHT TO DECIDE

www.hendersonbh.org

You have a right to fill out a paper known as an "Advance Directive". This paper says what kind of treatment you want or do not want under special, serious medical conditions-conditions that would stop you from telling your doctor how you want to be treated.

What is an Advance Directive?

An Advance Directive is written or oral statement, which is made and witnessed in advance of serious illness or injury, about how you want medical decisions made.

An Advance Directive allows you to state your choices about health care or to name someone to make those choices for you if you become unable to make decisions about your medical treatment.

What is a Living Will?
A Living Will generally states the kind of medical care you want or do not want if you become unable to make your decisions. It is called a "Living Will" because it takes affect while you are still living. Florida law provides a suggested for a Living Will. You may wish to speak to an attorney or physician to be certain you have completed the Living Will in a way so that your wishes will be understood.

WHAT IS A HEALTH CARE SURROGATE DESIGNATION?

A Health Care Surrogate Designation is a signed, dated, and witnessed paper naming another person such as a husband, wife, daughter, son, or close friend as your agent to make medical decisions for you if you should become unable to make them for yourself. You can include instructions about treatment you want or wish to avoid. Florida law provides a suggested form for the designation of a Health Care Surrogate. You may wish to name a second person to stand in for you if your first choice is not available.

All adult individuals in health care facilities such as hospitals, nursing homes, hospices, home health agencies and health maintenance organizations, have certain rights under Florida law. If you believe you may be hospitalized for mental health care in the future and that your doctor may think you aren't able to make good decisions about your treatment, then completing a mental health advance directive will ensure that your treatment choices are known.

It is important that you decide **NOW** what types of treatment you do or do not want and to appoint a friend or family member to make the mental health care decisions that you want carried out. You may always change your preferences or surrogate later.

If I did not designate a health care surrogate or have a court appointed guardian, who would make the decisions on my behalf if I was in the hospital and unable to make them myself?

According to Florida law, the following individuals would make these decisions. They are, in the order of priority:

1. Spouse (Florida law does not recognize common law marriages as a legal marriage contract).
2. Adult children who are reasonably available for consultation (in person or by phone).
3. Parent(s).
4. Sibling(s) who are reasonably available for consultation (in person or by phone). Being the oldest child does not give that child any higher priority.
5. Relative who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health and religious or moral beliefs.
6. Close Personal Friend - to qualify, the friend shall be 18 years of age or older, have exhibited special care and concern for the patient; has signed a Close Personal Friend affidavit stating he or she is a friend of the patient; and is willing and able to become involved in the patient's healthcare and has maintained regular contact with the patient so as to be familiar with the patient's activities, health and religious or moral beliefs.

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765. Florida Statutes).

NSU Center for Student Counseling and Well-Being
3301 College Ave., SAB 3rd Floor, Davie, FL 33314
PHONE: (954) 424-6911 or (954) 262-7050 FAX: (954) 424-6916

Henderson Student Counseling Services

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CENTER FOR STUDENT COUNSELING AND WELL-BEING

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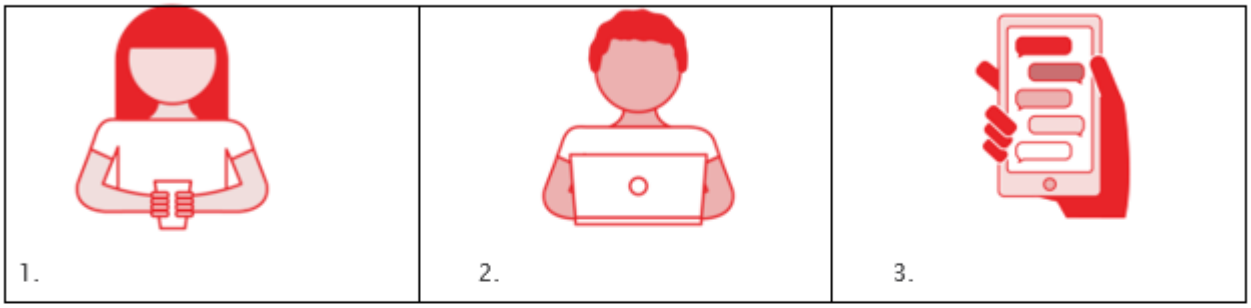
CRISIS TEXT LINE |

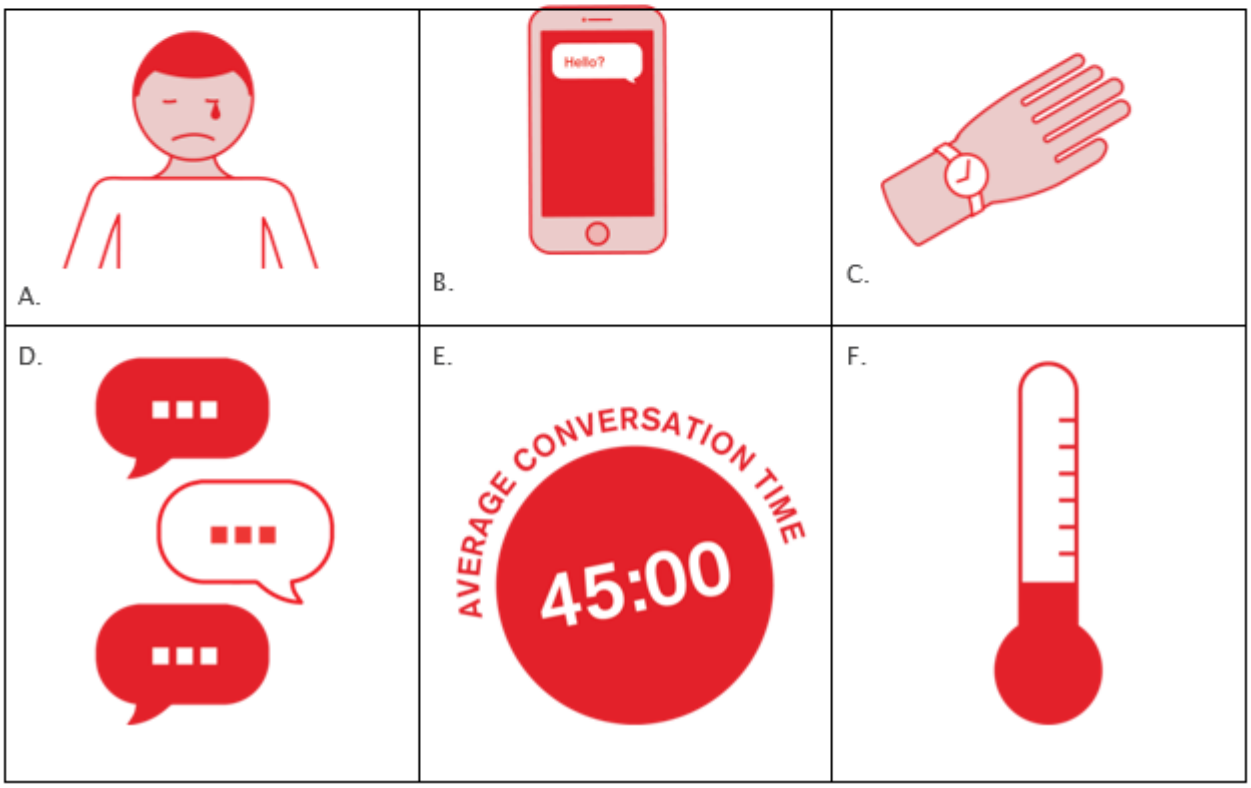
How it Works

THE SHORT VERSION



1. Text HOME to 741741 from anywhere in the US, anytime, about any type of crisis.
2. A live, trained Crisis Counselor receives the text and responds quickly.
3. The volunteer Crisis Counselor will help you move from a hot moment (intense feelings) to a cool moment (safe).

AND IN A BIT MORE DETAIL...



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CRISIS TEXT LINE

How it Works (continued)

A. First, **you're in crisis**. That doesn't just mean suicide: it's any painful emotion for which you need support. You text us at 741741. Your opening message can say anything: The opt-in words you see advertised ("HELLO," "START") just help us know where people are learning about us!

B. **The first two responses are automated**. They tell you that you're being connected with a Crisis Counselor, and invite you to share a bit more. The Crisis Counselor is a trained volunteer, not a professional. They can provide support, but not medical advice.

C. It usually takes less than five minutes to connect you with a Crisis Counselor. (It may take longer during high-traffic times). **When you've reached a Crisis Counselor**, they'll introduce themselves, reflect on what you've said, and invite you to share at your own pace.

D. You'll then text back and forth with the Crisis Counselor. **You never have to share anything you don't want to.** The Crisis Counselor will help you sort through your feelings by asking questions, empathizing, and actively listening.

E. **The goal of any conversation is to get you to a calm, safe place.** Sometimes that means providing you with a referral to further help, and sometimes it just means being there and listening. A conversation usually lasts about 45 minutes.

F. The conversation typically ends when you and the Crisis Counselor both feel comfortable deciding that you're in a "cool," safe place. **After the conversation, you'll receive an optional survey** about your experience. This helps us help you and others like you!

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Universal Precautions

Universal Precautions are to be followed at all times. They are designed to keep both the staff and clients as healthy as possible. Please always:

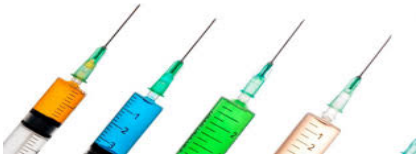
Wash your hands frequently - after using the restroom, when handling food or trash, before eating, after coughing or sneezing or coming in contact with someone who is sick. Use soap and rub your hands together for 20 seconds. Turn off the faucet with a paper towel & dry your hands thoroughly.

Gloves should be worn - whenever there is contact with another person's bodily fluids. Any items with blood on them must be disposed of properly in a BioWaste container.

When sick, stay home - the best way to prevent the spread of an illness is to stay away from person's who are sick. Always cover your mouth when sneezing or coughing - turn your head toward your elbow if no tissue is available.

Use bug spray – (Non-Deet) and wear protective clothing, especially at dawn and dusk, to prevent Zika and other mosquito borne illnesses.

Get vaccinated! - Please get all vaccines your doctor recommends.



Let's stay healthy together!

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