Student Center for Health and Counseling
Counseling Services

Telehealth Informed Consent Form

I_____, consent to engage in telehealth with the Student Center for Health and Counseling as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,
3. I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of The Student Center for Health and Counseling that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telehealth based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to a mental health professional who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.
4. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of audio/video systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold the Student Center for Health and Counseling or its staff liable for gathering or use of client information by these service providers.
5. It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
6. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
7. We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
8. I have read and understand the information provided above. I have discussed these points with my counselor, and all of my questions regarding the above matters have been answered to my approval.
9. By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document I understand that an emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening/emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.
10. Providing verbal consent to information reviewed will act as written consent and my therapist will document verbal consent in lieu of a signature.

_____ _____

Signature of Client | Date of 1st Telehealth Appointment

_____ _____

Signature of Mental Health Professional | Printed Name of Mental Health Professional