

HSU Counseling and Psychological Services

TeleHealth Informed Consent Form

I, _____ (client name), hereby consent to engage in telehealth with a therapist at HSU's Counseling and Psychological Services (CAPS). I understand that **psychological care and support** are being provided through technology (phone and ZOOM Health interactive video) as a response to a nationwide health concern, Coronavirus and COVID-19, and the need to provide services remotely for a short time. I understand that, telehealth psychotherapy may include any of the following components: psychological care delivery, diagnosis, consultation, education, problem solving, skills training, referral to resources, and help with decision-making. This service is not being offered as a substitute for regular face-to-face services at CAPS which will be resumed when local circumstances return to normal.

I understand that I have the following rights & responsibilities with respect to telehealth:

- 1) I understand that to engage in teletherapy requires that I have a private space along with a good internet connection and a computer or tablet (ideally) or a smartphone.
- 2) I have the right to withhold or withdraw consent at any time. Consent should be withdrawn in writing and will be applicable to all future services (but cannot be withdrawn for services already provided).
- 3) If an onsite intake was not possible (due to illness and/or quarantine restrictions), I understand that the therapist with whom I meet through telehealth will do some basic assessment over the phone/Zoom in order to assess for possible contraindications of using these limited telehealth services, including, but not limited to:
 - a. Recent suicide attempt/s, psychiatric hospitalization/s, or evidence of active psychosis
 - b. Moderate to severe alcohol and/or drug abuse
 - c. Severe eating disorders
 - d. Repeated "acute" crises
- 4) I understand that telehealth services require that I be a currently enrolled HSU student and that I must be physically located in California for the duration of these services.
- 5) I understand that there are risks and consequences from telehealth, including, but not limited to:
 - a. The possibility, despite reasonable efforts on the part of the therapist, that the transmission of my personal information could be disrupted or distorted by technical failures or unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons.
 - b. Potential shortcomings of the use of this medium that could limit the effectiveness of therapy as compared to face-to-face services. For example, I understand that the therapist may have an inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your apparent height and weight, gait and motor coordination, posture, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), chronological and apparent age, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what they would consider important information, information that I may not recognize as significant to present verbally to the therapist.
 - c. As with all mental health services, my condition may not improve, and in some cases may even get worse. Therapy may elicit uncomfortable thoughts and feelings, or may

lead to the recall of troubling memories. Often, therapy leads to positive outcomes, but results cannot be guaranteed or assured.

- 6) EMERGENCIES: If I experience a need for immediate psychological help (e.g., due to suicidal or homicidal intent or behaviors) I will call 911 for emergency help. I understand that campus police can be reached at 707.826.5555, Humboldt County Mental Health (720 Wood St, Eureka) at 707.268.2900, and the National Suicide Hotline at 1.800.784.2433
- 7) CONFIDENTIALITY: I understand that CAPS takes my privacy seriously and requires my written consent to discuss my care outside of the center (with exceptions outlined below). I know that within the center, my therapist may discuss my care with other CAPS clinicians and the SHWS psychiatrists. Limited aspects of my care may also be discussed with Student Health and Counseling medical providers (e.g., in situations where there are safety and/or medication concerns). I understand that circumstances in which CAPS is AUTHORIZED or REQUIRED by law to disclose information outside of Health & Counseling include:
 - a. In cases of considerable risk of serious or life-threatening harm to self or other/s
 - b. In cases of confirmed or suspected abuse or neglect of a minor
 - c. In cases of confirmed or suspected abuse/neglect of an elder or dependent adult
 - d. In legal proceedings when there is a court-order to release information
- 8) CONFIDENTIALITY for those engaged in GROUPS: I understand that video conferencing technology for groups poses more risks to my confidentiality than do equivalent in-person services. My CAPS group leaders are unable to guarantee the privacy of the meeting space or appropriate use of technology of each group member. For example, privacy could be interrupted by the housemate or family member of a group member and this could cause a breach in my confidentiality. I am willing to take this risk and will not hold CAPS liable for a breach of confidentiality that is outside of their control.
- 9) I understand that my CAPS RECORD is stored electronically in a secure environment which meets legal and ethical requirements for medical and psychological records.
- 10) I understand that I have a right to access my personal information and copies of case records in accordance with California law. I further understand that I have the right to authorize CAPS to disclose information in my counseling record through a written Release of Information (ROI). I may cancel the authorization at any time by giving CAPS written notice.
- 11) I understand that if my therapist is not yet licensed, I will be informed of their status and of the identity and contact information of their supervisor.
- 12) I have read and understood the information provided above. I am satisfied that I have had opportunity to have any questions or concerns addressed by my therapist. By electronically signing this document, I agree that certain situations including emergencies and crises require services beyond telehealth.
 - a. If I am experiencing an emergency, I understand that I should immediately call 911 or seek help from a local hospital or Humboldt County Mental Health at 707.268.2900 located at 720 Wood Street, Eureka. I understand that emergency situations include having intent and/or plans to kill myself or someone else; onset of hallucinations and disordered thinking; and/or if I am in danger due to use of alcohol or drugs.

Signature of Client _____

Date _____ *

*Consent is good for one year from today.

Are you age 18 years or older: Yes ____ No ____

(If no, CAPS may require parental consent for treatment. You will discuss this with your therapist).

