Chapman University - Student Psychological Counseling Services
TeleHealth Informed Consent Form

I (name of client) hereby consent to engaging in telehealth with a clinician at Chapman University's SPCS. I understand that "telehealth" includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making. Telehealth psychotherapy may include psychological health care delivery, diagnosis, consultation, and psychotherapeutic treatment. Telehealth psychotherapy will occur primarily through interactive audio, video, telephone, email, instant messaging, and/or other data communications.

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

(1) I have the right to withhold or withdraw consent at any time. If consent is withheld or withdrawn, I may request a referral to a local mental health provider.

(2) I must complete an individual screening by an SPCS Clinician before participating in telehealth. The clinician will inform you if a referral for telehealth services is appropriate. Receiving telehealth services may be not be appropriate for students with:

- Recent suicide attempt(s), psychiatric hospitalization, or psychotic processing (last 3 years)
- Moderate to severe major depression or bipolar disorder symptoms
- Moderate to severe alcohol or drug abuse
- Severe eating disorders
- Repeated “acute” crises (e.g., occurring once a month or more frequently)

(3) For a Chapman University student to receive telehealth services, they must be physically located in a state where the telehealth provider is licensed (i.e., California) *at the time of the appointment*. Telehealth service may not be provided in international jurisdictions. Therefore, students who are physically out of California, should seek out services local to them.

(4) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; expressed threat to harm or kill self; and where I make my mental or emotional state an issue in a legal proceeding. 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.

(5) 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 clinician, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my clinician believes I would be better served by another form of intervention (e.g. face-to-face services) I will be referred to a mental health professional who can provide such services in my area.

Finally, I understand that there are potential risks and benefits associated with any form of counseling, and that despite my efforts and the efforts of my clinician, my condition may not improve, and in some cases may even get worse.

(6) I understand that I may benefit from telehealth psychological counseling, but that results cannot be guaranteed or assured.

(7) I understand that I have a right to access my personal information and copies of case records in accordance with Federal and California law. I have read and understand the information provided above. I have discussed it with my clinician, and all of my questions have been answered to my satisfaction.

(8) I give permission to SPCS personnel to email me at my given address and I give permission to SPCS personnel to contact me and leave a message for me at my preferred contact number.

(9) By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychological counseling services.

- If I am in crisis or in an emergency I should immediately call 9-1-1 or seek help from a hospital or crisis oriented health care facility in my immediate area. I understand that emergency situations include if I have thought about hurting or killing either another person or myself, if I have hallucinations, if I am in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs.
- I acknowledge I have been told that if I feel suicidal, I am to call 9-1-1 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

THIS IS YOUR COPY.

We hope your experience at SPCS is a positive one.

Thank you!