

Kutztown University Counseling & Psychological Services

This document is an addendum to the Kutztown University Counseling & Psychological Services standard informed consent and does not replace it. All aspects of informed consent for treatment in that document apply to tele-health services.

TELEMENTALHEALTH CONSENT FORM (REQUIRED IN THE EVENT TELEHEALTH IS NECESSARY) Definition of Services:

I, _____ (Client Name), hereby consent to engage in telehealth services with Kutztown University Counseling & Psychological Services (KUCPS).

Telementalhealth (TMH) services are a form of psychological services provided via telecommunications technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that TMH services involve the communication of my medical/mental health information, both orally and/or visually. **TMH services** are offered to improve access to mental health services to Kutztown University students during major crises, such as COVID-19. However, the results of TMH services cannot be guaranteed or assured. I am not required to use TMH services and I have the right to request other service options or withdraw this consent at any time without affecting my right to future care or treatment at KUCPS.

Teletherapy, a specific form of TMH services, has the same purpose or intention as psychotherapy sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face to face treatment sessions. **Teletherapy** may not be appropriate, or the best choice of service for reasons including, but not limited to: heightened risk of harm to oneself or others; lack of access to, or difficulty with, communications technology; significant communications service disruptions; or need for more intensive services. In these cases, KUCPS will help me establish referrals to other appropriate services.

Client's Rights, Risks, and Responsibilities

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

1. I, the client, need to be a resident of Pennsylvania in order to receive teletherapy services. (This is a legal requirement for mental health professionals practicing in this state under a PA license).
2. I understand that if I reside outside of Pennsylvania, TMH services may be limited to telephone case management services, including assistance with identifying referrals for services in my geographic area. (This is due to state laws limiting the practice of licensed mental health professionals in states other than the one by which they are professionally licensed).
3. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
4. The laws that protect the confidentiality of my medical information also apply to TMH services. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent form I received at the start of my treatment with KUCPS, if applicable.
5. I understand that there are risks and consequences of participating in TMH services, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
6. There is a risk that services could be disrupted or distorted by unforeseen technical problems.
7. I will not record any sessions, nor will KUCPS record my sessions without my written consent.

8. Email is not a confidential method of communication, and my counselor may not access or respond to emails quickly. If I choose to contact my counselor by email, I will not include private information, and I will not expect a prompt response. I understand that my e-mail communications may be viewed by other staff at KUCPS and that my e-mail communications will be stored electronically as treatment records.
9. If I need to reach my provider between sessions, I understand that I may call KUCPS during business hours to leave a message requesting a return call.
10. If a TMH contact is interrupted for any reason, such as the technological connection fails, and I am having an emergency, I will not attempt to call my provider back; instead, I will call 911 or go to my nearest emergency room. I will call KUCPS back with an update after I have called or obtained emergency services.
11. If a TMH session is interrupted and I am not having an emergency, my provider will attempt to reach me via a backup method; for example, if I am engaged in a videoconferencing session, my provider may contact me by telephone if our session is interrupted.

Client Signature: _____ Date: _____

In Case of an Emergency

Emergency Procedures Specific to Telehealth Services

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, your provider may determine that you need a higher level of care and Telehealth services are not appropriate.

Your provider requires an Emergency Contact Person (ECP) who they may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

You will verify in advance that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or your provider determine it is necessary, the ECP agrees take you to a hospital. Your signature on this document indicates that you understand your provider will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

Name: _____

Phone Number: _____

You agree to inform your provider of the address where you are at the beginning of every session. You agree to inform them of the mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

Please list this hospital and contact number here:

Hospital: _____

Phone: _____