**Informed Consent for Telehealth**

Indiana State University

Student Counseling Center

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of student) hereby consent to engaging in telehealth counseling with a mental health provider at ISU’s Student Counseling Center. Telehealth is a broad term that refers to mental health services and information provided electronically or with the use of technology. I understand telehealth counseling may include mental health education, diagnosis, consultation, treatment, and referrals to resources. Telehealth counseling with the Student Counseling Center will occur primarily through telephone conversations at this time, but could eventually include secure videoconferencing and may involve some email exchanges.

I acknowledge that, as result of an ongoing public health emergency caused by COVID-19, the U.S. Department of Health and Human Services has decided to temporarily waive certain regulations issued under the Health Insurance Portability Act of 1996 (“HIPAA”) governing the provision of telehealth services. Accordingly, I understand that my telehealth counseling may be conducted utilizing third-party communication applications that may not fully comply with HIPAA regulations but that these applications potentially introduce privacy risks not normally present during telehealth counseling conducted using HIPAA compliant software.

In order to engage in telehealth with the ISU Student Counseling Center you must confirm that you are physically in the state of Indiana and must provide your location to your counselor before each session. We ask that you also provide us with an emergency contact near your location that we can call if you are in crisis and/or your counselor is unable to reach you.

Name: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address during session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nearest Hospital to your location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 If consent is withheld or withdrawn, students may meet with a provider onsite at the Student Counseling Center office. In some instances where meeting at physical location is not possible, your provider may need to refer you to another community mental health provider who can appropriately provide this service.
2. The use of telehealth counseling is subject to the discretion of a Student Counseling Center mental health provider, is temporary in a nature, and based upon the assessment of a student’s clinical needs.

Telehealth counseling will only begin after having contact with a Student Counseling Center mental health provider and after they have determined that such counseling is appropriate for your care. For existing clients of the Student Counseling Center, this transition may occur as part of your on-going care. For new clients, telehealth counseling will only occur after participating in a screening. The provider will inform you if participating in telehealth counseling is appropriate. Receiving telehealth counseling may be contraindicated with:

* + Recent suicide attempt(s), psychiatric hospitalization, or psychotic symptoms.
	+ A clinical presentation with severe physical symptoms (e.g. severe eating disorder, severe depression) that requires medical attention.
	+ Moderate to severe substance abuse or dependence symptoms
	+ Severe eating disorders
	+ Repeated “acute” crises (e.g., occurring once a month or more frequently)
1. For a student to receive telehealth counseling, they must be physically located in Indiana at the time of their session. Your counselor will confirm your location before each session. Telehealth service cannot be provided across state lines or in international jurisdictions.
2. Telehealth counseling appointments occur at the times agreed upon between you and your provider. If you miss your scheduled appointment, you must contact your provider or the Student Counseling Center main office (812-237-3939) in order to reschedule.
3. Telehealth counseling cannot be provided to students who are minors, unless this consent form is also signed by a parent or guardian.
4. The laws that protect the confidentiality of your personal information and clinical treatment record also apply to telehealth counseling. As such, I understand that the information disclosed by me during the course of telehealth counseling sessions is generally confidential. However, there are exceptions to confidentiality, including, but not limited:
	* The student is in imminent danger of harm to self or others and it is necessary to ensure the student’s and/or other’s safety.
	* The provider has reason to suspect the presence of abuse or neglect of a child, an elderly person, or dependent adult; and must make a mandatory report to DCS.
	* A Student Counseling Center staff member is presented with a valid court order.
	* The client is a minor and information is requested by their parent or guardian.
5. I understand that my sessions via telehealth counseling will not be recorded by the Student Counseling Center provider, nor am I to record the session without written consent. I understand that the dissemination of any personally identifiable images or information from the telehealth counseling interactions to other entities shall not occur without my written consent.
6. I understand that there are risks and consequences from telehealth counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, 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.

Another risk is that students may experience loss of confidentiality due to factors from the surrounding environment in which they chose to participate in telehealth counseling. Students are encouraged to ensure that no one else is the room, not to participate in conversations while on speaker phone, and not to participate in conversations in a public space.

In addition, I understand that telehealth counseling may not be as complete as face-to-face services. I also understand that if my Student Counseling Center mental health provider 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 I may benefit from telehealth psychological counseling, but that results cannot be guaranteed or assured. 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 provider, my condition may not improve, and in some cases may even get worse.

1. I understand that there may be an incurred cost from participating in telehealth counseling (i.e. cost of phone call, use of minutes from a phone plan) and that I am responsible for covering these costs.
2. I understand that I have a right to access my personal information and copies of case records in accordance with Federal and Indiana law. I have read and understand the information provided above. I understand that if I have any questions I am free to discuss them with my counselor.
3. By signing this document I agree that certain situations including emergencies and crises are inappropriate for telehealth counseling services.
	* If I am in crisis or in an emergency I should immediately call 9-1-1 or the National Suicide Hotline at 1-800-784-2433; contact the crisis text line: <https://www.crisistextline.org/> text HOME to 741741, 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, if I am 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 contact other local suicide hotlines.

Your signature below indicates that you have read the information in this document and agree to abide by its terms while you are receiving services at the ISU Student Counseling.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\* For students who are under age eighteen:*

Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_