

Concord University Counseling Center Telehealth/Distance Counseling Informed Consent

Telehealth is the delivery of behavioral health services using interactive technologies (audio, video, or other electronic communications) between a provider and a client that are not in the same physical location. The interactive technologies utilized in telehealth incorporate network and software security protocols to protect confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and aid in protecting against intentional or unintentional corruption. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

I hereby consent to engaging in telehealth/distance counseling support services with the Concord University Counseling Center. I understand that “telehealth” or “distance counseling” includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making. Telehealth will occur primarily through interactive audio, video, telephone, email and other data communications

I understand that I have the following rights and responsibilities with respect to telehealth/distance counseling:

1. I have the right to withhold or withdraw consent at any time. I may decline telehealth/distance counseling services at any time without jeopardizing my access to future care services or benefits. In the event that there are restrictions on face to face interactions mandated either by the university or government entities telehealth/distance counseling will be only means for you to access this service. Should you decline you will be referred to a provider in your area.
2. This service is provided by technology (including but not limited to video, phone, and email) and may involve direct face to face communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery. During a virtual counseling session, details of my medical history and personal health information will be discussed through the use of interactive video, audio or other telecommunications technology.
3. I must complete a screening by a Concord University Counseling Center staff member before participating in telehealth/distance counseling. In the event that the university has moved to alternate forms of instruction due to emergencies or crises other than face-to face learning, students will have an intake performed via telehealth.
4. I understand that telehealth services may not be appropriate for students with:
   1. If self-harm is imminent
   2. Recent suicide attempt(s), psychiatric hospitalization, or psychosis
   3. Moderate to severe major depression
   4. Moderate to severe alcohol and/or drug use
   5. Severe eating disorders
   6. Repeated “acute” crises (occurring once a month or more frequently)

As a student you will have the option to choose telehealth/distance counseling support services or a face to face session if you wish. In the event that college offices close, you can utilize telehealth/distance counseling support services.

1. I understand that telehealth/distance counseling services and care may not be as complete as face to face services. I also understand that if my counselor believes I would be better served by another form of intervention, I will be referred to a mental health professional who can provide such services. If the need for direct, face to face services arises, it is my responsibility to contact professionals in my area such as the local mental health center, a hospital emergency department, or to contact my behavioral health practitioner’s office for a face to face appointment or my primary care provider if my behavioral health provider is unavailable. I understand that an opening may not be immediately available in either office.
2. I understand that if I am in a crisis or emergency I should immediately call 911 or seek help from a local hospital. Other options available for emergency support include the National Suicide Hotline at 1-800-273-8255 or HELP For WV at 844-435-7498.
3. 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 counselor, my condition may not improve, and in some cases may even get worse.
4. I understand that I may benefit from telehealth counseling, but that results cannot be guaranteed or assured.
5. I understand that I have a right to access my personal information in accordance with Federal and WV law.
6. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technologies we have agreed upon today, and modify our plan as needed. I understand that therapy provided by this means is different from in-person therapy and that if my therapist believes that I would be better served by another form of psychotherapeutic services I will be referred to a therapist/facility in my geographic area that can provide such services.
7. In emergencies, in the event of disruption of services, or for routine administrative reasons, it may be necessary to communicate by other means:
   1. In emergency situations: by telephone
   2. Service disruption: by telephone
   3. For other communication: campus email, other email platforms, postal delivery
8. My counselor may utilize alternative means of communication in the following circumstances: video connections fail or phone line access is disrupted.
9. My counselor will respond to communications and routine messages within 48 hours on business days or on the next business day following weekends, holidays or vacations.
10. It is my responsibility to maintain privacy on the client end of communication.
11. I will take the following precautions to ensure that my communications are directed only to my behavioral health practitioner: double check email addresses, phone numbers, double check to whom email is sent (reply vs reply all)
12. My communication with my behavioral health practitioner will be stored in the following manner: In compliance with HIPAA regulations in secured file cabinets and/or secured electronic files.
13. The laws and professional standards that apply to in-person behavioral health services also apply to telehealth services. This document does not replace other agreements, contracts or documentation of informed consent previously signed in the Counseling Center.
14. I understand that I may discuss any questions and/or concerns about telehealth/distance counseling with a Concord University Counseling Center staff member.

By electronically signing this document I affirm that I have read and understand the information provided above. I further affirm, that I was given the opportunity to discuss any questions and/or concerns with a Counseling Center staff member, and that all of my questions and/or concerns have been answered before signing. I affirm that I agree to engage with telehealth/distance Counseling support services offered by Concord University Counseling Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Legal Guardian Date

M. Marie Newcomb-Lewis, MSW, ACSW, LCSW, LPC

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Practitioner Date