Informed consent for telehealth sessions

1. I understand that "telehealth" includes secure videoconferencing, secure messaging, and telephone conversations using interactive audio, video, or data communications.

2. Unless I explicitly provide agreement otherwise, telehealth exchanges are strictly confidential. Any information I choose to share with my provider will be held in the strictest confidence. My private information will not be released by CHWS unless it is required by law, as you were informed in the CHWS Informed Consent to Treatment for Counseling Services, the Agreement to Treat for Medical Services, and the Privacy Practices.

3. I understand that if I participate in a group format service that I will take reasonable steps to ensure privacy for myself and others by selecting a private location in which I will not be disturbed. I understand that there are additional limitations to the confidentiality of the content I discuss with my peers. Also, if I agree to participate in a group, I agree not to release the personal identity or information of any group members without their permission.

4. I understand that telehealth services will be only be available during the time that has been scheduled for the client/patient and the provider.

5. I understand that I have the right to withdraw or withhold consent for telehealth services at any time. I also have the right to terminate treatment at any time.

6. Cost for telemedicine medical services will be $20 per visit. This fee will be transferred to your student account. Prescriptions will be sent to a local pharmacy for patient pick up.

7. While telehealth will be conducted primarily through secure and private videoconferencing, I understand that there are always some risks with telehealth services including, but not limited to, the possibility that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.

8. I will work with my provider to identify an alternative communication method (most often phone) in the event that the videoconferencing tool fails.

9. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.

10. I understand and accept that telehealth does not provide emergency services. If I am experiencing an emergency, I understand that the protocol would be to call 911 or proceed to the nearest hospital emergency room for help. If I am experiencing suicidal thoughts or making plans to harm myself, I may call the National Suicide Prevention

Lifeline at 1- 800-273-TALK (8255) or the Pierce County Crisis Line at 1-800-576-7764 for free 24-hour hotline support.

11. I will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access to participate in telehealth sessions, (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions.

12. I agree not to record telehealth sessions.

13. I agree to be dressed as if I were attending an in-person face to face session.

14. I have the right to access my medical and/or counseling information and copies of my records in accordance with HIPAA privacy rules and applicable state law.

15. I understand that services delivered by my CHWS provider are required by law to take place within the state of Washington, as the CHWS providers are licensed in Washington. There may on rare occasions be an exception for crisis consultations or to assist with out of state referrals for continuity of care. If I am physically located outside of the state of Washington I will immediately notify my CHWS provider. I understand my CHWS provider will refer me to locate support and resources within the state I am located.

16. I understand that my CHWS provider may attempt to call me by phone if during a videoconference there is a technology failure. My CHWS provider may attempt to call me by phone if I do not show for a scheduled video conference. In addition, if you are showing signs of being in a medical or mental health crisis/emergency, CHWS requires that we have permission to contact someone to ensure your safety. We require three levels of contacts:

    1) a close personal contact such as a parent, partner, or spouse

    Personal Contact:
    Name: _____ Relationship: _____

    Phone: _____

    2) professional contact such as a student affairs professional, a residence hall director, or a personal physician

    Professional contact:
    Name: _____ Relationship: _____

    Phone: _____

    3) The office or Agency that does crisis well-being checks in your community (typically a 24-hour crisis service or the police department).

Crisis response: _____

My physical address is: _____
_____

Signature of patient/client is required below or you may reply to a secure message indicating you agree to this informed consent and in your reply provide CHWS with the three listed emergency contacts.

_____

Print name: _____

Date: _____