MONMOUTH UNIVERSITY | COUNSELING *and* PSYCHOLOGICAL SERVICES

Informed Consent Agreement for Telehealth Services

I, Insert Student Name here, hereby consent to engaging in telehealth services with a mental health provider from Counseling & Psychological Services (CPS). Telehealth is a broad term that refers to mental health services and information provided electronically or with the use of technology. I understand telehealth services may include mental health education, problem-solving, skills training, help with decision-making, diagnosis, consultation, treatment, and/or referrals to resources. Telehealth services with CPS will occur primarily through telephone and videoconferencing and may involve exchanges through My Student Health portal.

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

1. I have the right to withhold or withdraw consent at any time for telehealth services through CPS, at which point telehealth services will terminate.

2. The use of telehealth services is subject to the discretion of a CPS mental health provider, is temporary in nature, and based upon the assessment of a student's clinical needs.

Telehealth services will begin with a CPS mental health provider to determine that such services are appropriate. For existing clients of CPS, this transition to telehealth services may occur as part of your ongoing care. For new clients of CPS, telehealth services will begin with a screening. The provider will inform you if participating in telehealth services is appropriate.

Please note that receiving telehealth services 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 self-injury, severe depression) that requires medical attention.
- Moderate to severe substance abuse or dependence symptoms.
- Repeated "acute" crises (e.g., occurring once a month or more frequently).
- Lack of access to, or difficulty with, communication technology.

3. For a student to receive telehealth services, they must be physically located in a state where the provider is licensed (i.e., New Jersey). Telehealth services cannot be provided to individuals who are physically outside of the State of New Jersey (including international locations). Restrictions may be waived under certain circumstances.

4. Telehealth appointments will occur at the times agreed upon between you and your provider. If you miss your scheduled appointment, you must contact your provider or the CPS main office at mucounseling@monmouth.edu in order to reschedule. CPS reserves the right to cease telehealth appointments after 2 missed appointments.

6. The laws that protect the confidentiality of your personal health information and clinical treatment record also apply to telehealth services. As such, I understand that the information disclosed by me during the course of telehealth services is generally confidential. However, there are exceptions to confidentiality, including, but not limited to situations where:

- The student is in imminent danger of harm to self or others and disclosure 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 the appropriate authorities.
- A CPS staff member is presented with a valid court order that mandates disclosure.

7. I understand that my telehealth appointments will not be recorded by the CPS provider, and I agree to not record them, as well. I understand that the dissemination of any personally identifiable images or information from the telehealth interactions to other entities shall not occur without my written consent, or except in the cases already mentioned.

8. I understand that there are risks and consequences from telehealth services, including, but not limited to the possibility, despite reasonable efforts on the part of the mental health provider, 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.

9. I understand that there are risks of loss of confidentiality due to factors from the surrounding environment in which I chose to participate in telehealth services. I understand and acknowledge that I am encouraged to ensure that no one else is the room, not to participate in conversations while on speakerphone, or to participate in telehealth services in a public setting.

10. I understand that telehealth services may not be as complete as face-to-face services. I also understand that if my CPS mental health provider believes I would be better served by another form of intervention (e.g. face-to-face service; higher levels of care), I will be referred for alternative arrangements for services.

11. I understand that I may benefit from telehealth psychological services, 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.

I certify that I have carefully read and understand this Informed Consent Agreement for Telehealth Services before signing it.

By signing my name and inserting the date, I acknowledge and agree that I am voluntarily submitting an electronic signature indicating that I have read and agree to accept all of the terms and conditions set forth in this Agreement. It is recommended that I print a copy of this Agreement for my file. If I do not wish to submit an electronic signature, I may request that a paper copy be provided to me for signature. I further acknowledge and agree that a typed signature, facsimile copy, PDF, or photocopy of my signature hereto shall be valid and shall have the full force and effect as an original.

Signed: _____ Date: _____

Signature of Client/Patient's Legal Representative:_____

Emergency Contact Name: Insert Name of Emergency Contact

Emergency Contact Relationship to Student: Insert Relationship of Emergency Contact

Emergency Contact Telephone/Cellphone #: Insert Emergency Contact Tele/Cellphone #

If the client is unable to sign and email this consent back to their mental health provider, please send an email from your Monmouth email address to your mental health provider with the statement:

"I, [client's name], understand the information contained in this Informed Consent Agreement for Telehealth Services and voluntarily agree to participate in telehealth services."