Oklahoma State University – University Health Services

Consent for Teletherapy Treatment

I, (NAME)____(CWID)____________ give written consent to engage in teletherapy with Oklahoma State University (OSU) University Health Service (UHS) in accordance with the following expectations and guidelines.

Description of Teletherapy Services

1. "Teletherapy" is the practice of health care delivery, diagnosis, consultation, and therapeutic treatment that occurs through a HIPPA compliant, interactive, web-based audio and video communications platform.

Technology Service and Protocol

2. UHS will utilize the HIPPA compliant TAO Therapy Assistance Online platform to provide teletherapy services. If this form of technology is not accessible to the OSU user or fails in the course of a teletherapy session, telephone conferencing may be utilized as an alternative form of communication.
3. I agree to provide a back-up phone number to my provider at the start of each session if we need to restart the session or reschedule it, in the event of technical problems.

Client Rights and Requirements

4. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the provider in advance by phone or by sending an electronic message via the OSU Patient Portal.
5. Services delivered by my provider are required by law to take place within the state or international jurisdiction in which my provider is licensed and in which I am located. If I am physically located outside of the state or jurisdiction in which my provider is licensed, I understand this is not a suitable condition for teletherapy and I will immediately notify my provider so that alternative referral services can be made.
6. I have the right to withhold or withdraw consent at any time. If consent is withheld or withdrawn, I have the option to request a referral to a local provider who can provide face-to-face meetings and/or wait until my provider is available to meet for a face-to-face session.
7. The laws that protect the confidentiality of my personal information in a face-to-face counseling setting also apply to teletherapy. The dissemination of any personally identifiable information from the teletherapy interaction to other entities shall not occur without my written consent except in the case of mandatory or permissive exceptions to confidentiality. Such exceptions include, but are not limited to:
    - suspected child, elder, and/or dependent adult abuse;
    - expressed threat of violence towards an identifiable victim;
    - expressed threat to harm or kill self; and
    - court subpoena.

8. I agree not to record and understand my provider will not record teletherapy sessions as doing so would breach confidentiality protocol.
9. I agree to be dressed as if I were attending a face-to-face session.
10. I agree to secure a private space that is free of distractions to conduct the teletherapy session.

Potential Risks of Teletherapy

11. There are potential risks of video-conferencing that differ from in-person sessions. Risks may include, but are not limited to the possibility, despite reasonable efforts on the part of the provider, that:
    - The transmission of communication could be disrupted or distorted by technical failures.
    - Despite best efforts to ensure high encryption and secure technology, there is risk that the transmission and electronic storage of my personal information could be breached and accessed by unauthorized persons. I understand that it is important to use a secure internet connection rather than public/free Wi-Fi in order to reduce these risks.
    - While I may benefit from services offered via teletherapy, results cannot be guaranteed or assured.

Contraindications for Teletherapy

12. Your provider may determine that due to certain circumstances, teletherapy is not appropriate. I understand my provider may recommend that we resume in-person sessions and/or I will be provided referral information when necessary.
13. Teletherapy services may not be advised if I have experienced any of the following high risk concerns:
    - recent suicide attempt(s), psychiatric hospitalization, or active psychosis within the last 3 years
    - moderate to severe major depression or bipolar disorder symptoms
    - moderate to severe alcohol or drug abuse
    - severe eating disorders
    - repeated "acute" crises (e.g., occurring once a month or more frequently)

Emergency protocol

14. I understand that certain situations, including emergencies and mental health crises, are NOT appropriate for teletherapy services and that I will utilize appropriate urgent/emergency services in the event any of the following occur:
    - thoughts of hurting or killing myself or another person;
    - hallucinations;
    - being in a life threatening emergency of any kind;
    - experiencing an emotional crisis; and/or
    - being under the influence of alcohol or drugs.

UNIVERSITY HEALTH SERVICES

15. I understand that my teletherapy provider may not be available for contact between scheduled sessions. If I am in an emergency or crisis situation (such as those listed above), I should seek immediate help. I agree to contact one of the following resources:
    - Call 911 or go the nearest Emergency Room
    - National Suicide Prevention Lifeline: Call 1-800-273-8255 (or another suicide hotline)
    - Crisis Text Line: Text HOME to 741741
    - OSU ComPsych Guidance Resources: 1-855-850-2397
    - Call SAM: 1-855-225-2SAM (2726)
    - Grand Lake Mental Health Crisis Line: 1-800-722-3611

16. I understand that we need a safety plan that includes at least one emergency contact and the closest Emergency Resource to my location in the event of a crisis situation.

My Emergency Contact	***Local Emergency Resource***
Name:	Name:
Phone Number:	Address:
Relationship:	Phone Number:

17. If I show indicators that I may be at serious risk of harm to self or others, I understand that OSU is required by law to contact appropriate emergency contacts such as campus police and/or emergency response personnel to ensure my safety or the safety of others.

My signature below confirms that I have read and understand the information provided above and that I agree to follow these guidelines and expectations for teletherapy services through OSU University Health Services.

Printed Name of Client : ____ CWID: ______________

Signature of Client: ____ Date: ______________

Signature of Guardian: ____ Date: ______________