California Lutheran University

Consent to Telehealth
ADDENDUM TO INFORMED CONSENT

In order to meet our clients' needs, California Lutheran University's Community Counseling Services (CCS) provides in person and telehealth services. By signing this form, you are agreeing to receive telehealth services as needed or requested while you are a CCS

This form is an addendum to the consent form you signed when you began receiving services through CCS. This document/agreement contains important information about the following:

1. Use of remote services
2. Privacy and confidentiality of remote services

It is important that you read this document carefully and ask any questions you might have prior to starting telehealth services.

By choosing to sign this form, I understand that the CCS cannot and does not guarantee the privacy or security of any session content or communication being sent through the internet, phone, email, or videoconferencing. Though unlikely, there is potential that videoconferencing sessions, emails, phone calls, or voicemails can be intercepted and reviewed by others, and it is possible that there could be disruptions to therapy due to technological difficulties. I understand that communicating via these mediums is not 100% secure. Similar to in-person sessions, sessions will be recorded and stored on a secure server. All other policies and procedures regarding recorded session information remain unchanged.

I consent to participate in counseling sessions or communication via the internet, phone, email, and videoconferencing with California Lutheran University's Community Counseling Services (CCS) as described below. My signature indicates that I have had the opportunity to ask questions about this modality and these questions have been answered to my satisfaction. These matters have been explained to me fully and I freely give consent to receive clinic evaluation and/or treatment services.

I consent to using **email** communication **only** for my telehealth appointment link using the following email: _____

I **do not** have access to a webcam/smart phone and need to do sessions by phone (Circle One): Yes No
In case session is interrupted, I can be reached at the following phone number: _____

CLU will be utilizing the following HIPAA-compliant platform: Webex

_____	_____	_____
Client/Parent/Guardian #1 Signature	Client/Parent/Guardian #1 Printed Name	Date
_____	_____	_____
Client/Parent/Guardian #2 Signature	Client/Parent/Guardian #2 Printed Name	Date
_____	_____	_____
Clinician/Witness Signature	Clinician/Witness Printed Name	Date

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The following information pertains specifically to the use of **videoconferencing and phone sessions**.

1. In-home telehealth services are available as a primary or occasional modality treatment. You may request them at any time.
2. Due to the sensitive material that is covered in each session, please be alone in the room (no family or friends), unless otherwise agreed upon with your mental health provider. This is to respect the confidentiality of your treatment.
3. Do not Video/Audio record the session.
4. Please do not call your therapist via video teleconferencing while you are driving or in a public area (e.g., public transit, at a restaurant)
5. Please call your provider at their voicemail if you are running late (Clinician #: _____).
6. Please dress as if you were going to an in-person appointment at the clinic.
7. Please have session in a private room with minimal distractions: Cellphones should be turned off or on vibrate, do not text during session, do not e-mail, use the internet, or engage in any other activities on the computer during sessions.
8. Please inform provider of any pets or people in the home at the time of session.
9. Please make sure that all televisions, radios, and any electronics (e.g., iPod, stereo) are turned off.
10. Please do not engage in other activities during sessions (e.g., cooking, cleaning, eating). Drinking water is okay.
11. No smoking, vaping or use of tobacco products during session.
12. Please do not attend sessions while under the influence of alcohol or other substances.
13. Please lockup all weapons (e.g., guns, knives, etc.) and remove them from the room where therapy will be occurring (via teleconferencing).
14. Please note if there are continuous difficulties with technology (audio/video) a recommendation for services by phone will be made.
15. Please be sure to have your devices fully charged prior to your scheduled appointment.
16. For best picture and audio quality, a hardwired connection (via LAN cable) rather than a wireless connection should be used if possible. Headphones add additional security.

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17. I agree to work with CCS to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions.

18. Technical problems could occur. If the call is disrupted, **the therapist will call back within ten minutes**. If reconnection cannot occur, the session will be rescheduled through phone or email.

19. Sessions will continue to be 45-minutes. Please ensure you have set-up your appointment at least 5-10 minutes **prior** to your appointment time.

20. If there is concern about me receiving sessions via telehealth, my clinician will discuss this with me and may suspend telehealth sessions and provide referrals, if needed.

I have been informed of and understand the risks and procedures involved with using the videoconferencing/phone technology. I agree to the terms listed above and I hereby voluntarily consent to the use of this platform for therapy sessions with my provider. I agree that CCS will not be held liable in the event that any outside party passes technology security and discovers personal or confidential information. This consent will last for the duration of the time telehealth services are offered at CCS. I can withdraw my consent for a telehealth session at any time, and CCS will work with me to find a suitable alternative.

_____	_____	_____
Client/Parent/Guardian #1 Signature	Client/Parent/Guardian #1 Printed Name	Date
_____	_____	_____
Client/Parent/Guardian #2 Signature	Client/Parent/Guardian #2 Printed Name	Date
_____	_____	_____
Clinician/Witness Signature	Clinician/Witness Printed Name	Date