Student Counseling Services

Information, Authorization and Consent to Treatment including Telemental Health

This document is designed to inform you about our Telemental Health services, including confidentiality, emergencies, and several other details, defined as follows:

Telemental Health means the mode of delivering services via technology-assisted media, such as but not limited to: telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. Telemental Health facilitates client self-management and support through synchronous and asynchronous interactions.

Telemental Health is a relatively new concept, even though many providers have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of Telemental Health services in order to provide you with the highest level of care. Therefore, all of our clinicians practicing Telemental Health services have received specialized training to ensure competence and ethical practice. We have also developed several policies and protective measures to guarantee your PHI remains confidential.

Structure of Sessions

We may provide phone or video conferencing if your service requirements determine that Telemental Health services are appropriate for you. We use the HIPPA compliant program Doxy.me to provide all Telemental Health services.

The structure of Telemental Health meetings are the same as face-to-face sessions described in the general " Description of Services" form. We agree to provide Telemental Health services within 45-50 minute duration.

In Case of Technology Failure

During a Telemental Health meeting, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Your provider will contact the number that you have provided in your initial paperwork. Please make sure you have this phone with you at all times during our session.

If you get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call the SCS office at (662-325-2091).

If we are on a phone session and we get disconnected, please call back or email your clinician to schedule another session. If the issue is due to our phone service, and we are not able to reconnect, this will not count as a missed session.

Your Responsibilities

Checking the boxes beside each statement indicates you have read and agreed to these responsibilities

- ☐ You understand that it is your responsibility as the client to find a secure, private, and quiet location where your session can occur uninterrupted. You are responsible for maintaining the confidentiality of your own electronic device and internet connection.
- ☐ You understand that at each session you must provide your actual location to your clinician. You understand that your clinician can only provide services to you as long as you are in the jurisdiction(s) in which they are licensed.
- ☐ You understand that it is your responsibility to inform your clinician via email if you cannot make your scheduled appointment. Cancelation or no showing of your scheduled appointment may result in a scheduling delay due to clinician demand.
- ☐ You understand that your appointment will only be scheduled during normal business hours (Monday-Friday 9a-4p) and that your clinician will not be available via video conference at times other than your scheduled appointment. Should you desire to speak with your clinician outside of your scheduled appointment, you understand that you should email them to check their availability. Your clinician is not available for crisis or emergency appointments.

Emergency Procedures Specific to Telemental Health Services

There are additional procedures that we need to have in place specific to Telemental Health services. These are for your safety in case of an emergency and are as follows. Checking the boxes beside each statement indicates you have read and understand these procedures.

- ☐ You understand that if you are having suicidal or homicidal thoughts, experience psychotic symptoms, or are in a crisis that we cannot solve remotely, your clinician may determine that you need a higher level of care and Telemental Health services are not appropriate.
- ☐ You understand that if you are suspected of being at imminent risk for being a harm to yourself or someone else during the teletherapy session, you will be instructed to dial 911 or go immediately to the nearest emergency department. If your clinician judges that you are at imminent risk to yourself or someone else, they will be expected to call 911 on your behalf and disclose your current location if you are unable or refuse to do so.

We require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or your provider will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or your provider determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand your provider will only contact this individual in the extreme.

Please list your Emergency Contact Person here: _____

Please list your Emergency Contact Person's phone number here: _____

We also require information regarding the nearest mental health hospital to your primary location in the event of a mental health emergency (usually located where you will typically be during a Telemental Health session).

Please list this hospital here: _____

Please list this hospital's contact number here: _____

Please digitally sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your clinician, and you are authorizing us to conduct Telemental Health treatment with you.

Clear Signature

Date: _____