Indiana Academy Office of Mental Health & Support Services
Telehealth Informed Consent Addendum

I hereby consent to engage in telehealth services with a therapist (therapist or therapist-in-training) from the Indiana Academy for Science, Mathematics, and Humanities Office of Mental Health and Support Services (OMHSS). I understand this informed consent is an addendum to the standard informed consent for treatment forms I previously completed. I understand that "telehealth" includes the practice of providing psychological assessment, therapy, counseling, and/or mental health treatment using electronic communication and information technology via video conferencing, telephone, or internet-based communication. Telehealth will occur primarily through interactive audio, video, telephone, and/or other data communications as determined by my therapist.

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 without jeopardizing my access to future care and/or services. If consent is withheld or withdrawn, I may request a referral to a local mental health provider.

(2) I understand that email is an unsecure form of communication and may be used to schedule appointments and for other administrative functions related to my appointments. I understand that email is not to be used for therapy or emergency services. I further understand that my therapist will use best efforts to respond to my emails within two business days.

(3) I understand that telehealth services are not appropriate for all concerns, and that my therapist will inform me if a referral for telehealth services is appropriate. Receiving telehealth services may be contraindicated with:

- Recent suicide attempt(s), psychiatric hospitalization, or psychotic processing
- Moderate to severe major depression or bipolar disorder symptoms
- Moderate to severe alcohol or drug abuse
- Severe eating disorders
- Repeated "acute" crises

(4) In order to receive telehealth services, I understand that I must live in a state where the therapist is licensed (i.e., Indiana).

(5) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential unless it meets specific criteria.

(6) I understand that The Indiana Academy OMHSS records and information are considered "Treatment Records" under the Family Educational Rights and Privacy Act ("FERPA"). I further understand that Cisco WebEx may be used for videoconferencing and offers encrypted and secure communication between my therapist and me.

(7) I understand that there are risks and consequences from telehealth services, despite reasonable efforts on the part of the therapist, including, but not limited to, the following: (i) the transmission of my personal information could be

disrupted or distorted by technical failures; (ii) the transmission of my personal information could be interrupted by unauthorized persons; and/or (iii) the electronic storage of my personal information could be accessed by unauthorized persons.

(8) I understand that telehealth services are innovative and may not be as comprehensive as face-to-face services, and that my symptoms may not improve. I also understand that if my therapist believes I would be better served by another form of intervention (e.g. face-to-face services), then I will be referred to a therapist who can provide such services in my area.

(9) I understand that if my telehealth appointment is interrupted due to technical issues, I can contact the Indiana Academy OMHSS (765-285-5483; mcwallpe@bsu.edu) to continue the appointment. If I need further technical support, I will contact BSU Help Desk (765-285-1517) or another appropriate service.

By signing this Informed Consent, I agree to not record my telehealth appointments.

By signing this Informed Consent, I agree that certain situations including emergencies and crises are inappropriate for telehealth services.

- If I am in crisis or in an emergency, I will immediately call 911 or seek help from a hospital or crisis-oriented health care facility in my immediate area. I understand that emergency situations include: (i) if I have thought about hurting or killing either another person or myself; (ii) if I have hallucinations; (iii) if I am in a life threatening or emergency situation of any kind; (iv) having uncontrollable emotional reactions; (v) or if I am dysfunctional due to abusing alcohol or drugs.
- I acknowledge I am aware that if I feel suicidal, I am to call 911 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

Consent for Services

I hereby certify that I am the legal guardian of the student (or a student age 18 or older) and consent to the terms of this "Telehealth Informed Consent Form" for the student. I understand that I can revoke my consent at any time.

Printed name of student	Date
Printed name of person authorized to consent	Signature of person authorized to consent