Counseling and Psychological Services Center
Appalachian State University

Authorization and Consent for Telemental Health Services
Acknowledgment in response to Coronavirus Disease 2019

In response to the Coronavirus Disease 2019 (COVID-19) national emergency and Appalachian State University's ("Appalachian's") transition to online services, the University is offering the ability for the Counseling and Psychological Services Center ("CAPS") to provide you with remote access services, including Telemental Health Services ("TMH").

TMH is defined as the provision of mental health care, delivery, assessment, diagnosis, consultation, treatment, and transfer of personal data, using interactive audio, video, or data communications. The purpose of these services is to assist with providing continuity of health and wellness consultation during this national emergency, while adhering to federal and state mandates and recommendations for remote access services for non-life threatening and non-emergency consultation.

Possible Benefits and Risks of TMH

- Benefits include the continued access and flexibility of mental health services without being physically present at CAPS. Furthermore, TMH provides access to care for those with limited physical mobility or transportation constraints.
- Potential risks may include:
    - technical interruptions, including the disruption, delay, or distortion of audio or video;
    - an increased risk of unauthorized disclosure to third parties of personal health information or other confidential personal data; and
    - reduction of visual and auditory cues that may impede mental health assessments.

Confidentiality and Recording:

Information and records that you provide to CAPS, as well as records and documents created by CAPS, in the scope of providing you with mental health care services is considered confidential under the Family Educational Rights and Privacy Act ("FERPA").

These confidential records are considered treatment records under FERPA and you do not have a right to review or access these records. However, FERPA does provide you with the ability to have these records reviewed by a physician or other appropriate professional of your choice. In limited situations, CAPS may use discretion to release records to you if we do not believe that the records would cause you harm. Furthermore, CAPS may release records to other appropriate individuals if the information is necessary to protect the health or safety of yourself or others, or as otherwise designated by federal and state law.

CAPS uses its best efforts to protect all confidential information. We have implemented appropriate technical and administrative procedures to safeguard data consistent with applicable privacy and data security laws. However, CAPS cannot guarantee the protection of any personal identifiable information we possess. CAPS will continue to use its best efforts to protect personal information for unlawful access or disclosure. Records created or received by CAPS are maintained for a minimum of seven (7) years.

Responsibilities of Clients

- Clients must use functional and secure technology with adequate internet access and connectivity, so that the client and clinician can clearly hear and/or see (when applicable) each other throughout the session;
- Clients must be in a physical space that is quiet, private, and free from distractions with no other individuals present, nor within earshot of the session;
- Client must notify the service clinician immediately if another person is present in the room or within earshot of the session;
- Clients must behave as if they are attending an in-person appointment (e.g., dress appropriately, attend the session on-time, refrain from activities such as texting or eating during session, etc.);
- Clients must notify the clinician at least 24 hours in advance, via phone or email, if an appointment needs to be cancelled or rescheduled; and
- Clients must inform the clinician of an emergency contact that may be contacted in the event of any immediate safety concerns who is in close proximity to the client.

Crisis and Emergency Situations

TMH is not intended for use in crisis or emergency situations. If you are experiencing an emergency (e.g., active suicidal or homicidal thoughts, symptoms of psychosis), you should contact emergency services in your area, the National Suicide Lifeline (1-800-273-8255), or call 911. If located in Boone, you may also contact the Counseling Center (828-262-3180) or the ASU Police Department (828-262-8000).

If the clinician becomes concerned for your immediate safety or threat to others (e.g., in the event you endorse active safety risk, do not attend a TMH appointment, intentionally disconnect a session before completion, etc.), the clinician may contact your emergency contact or relevant emergency personnel in your area to assess your well-being.

Additional Information

TMH may not be appropriate for every client for a number of reasons, including but not limited to heightened risk of harm to oneself or others; lack of access to, or difficulty with, communications technology; significant communications service disruptions; or need for more intensive services. In the event that the clinician determines that TMH is no longer the best fit for you or that TMH presents barriers to treatment, the clinician will discuss alternative treatment options with you including referral. Clinicians will establish an alternative session arrangement in the event that technology fails before or during a session.

CAPS Clinicians are either licensed in the state of North Carolina or under supervision of clinicians who are licensed in the state of North Carolina. State laws may require that the services delivered by clinicians take place within the state the clinician is licensed. Therefore, clinicians can only provide TMH to clients who are physically located in North Carolina at the time of the appointment. You must immediately notify the clinician if you are not located in North Carolina at the beginning of an appointment.

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Acknowledgement and Consent of Telemental Health Services

By participating in telemental health services, I understand that these services are not a substitute for emergency or life-threatening health care services and that I am responsible for seeking such treatment, if needed. I acknowledge that I may have a medical or wellness problem which may require additional medical attention and that telemental health services may not be adequate to meet such needs. Furthermore, you acknowledge that you have read and consent to the provisions referenced in the CAPS Service Agreement.

I certify that I am at least eighteen (18) years of age and authorized to accept the terms and conditions as expressed within this Acknowledgement, that I have read this entire Acknowledgment carefully, and that I understand the content of this Acknowledgment. I have agreed to accept telemental health services without any inducement and intend for my participation to serve as a confirmation of my complete and unconditional acceptance of receiving telemental health services.

I understand that I may withhold or withdraw consent to telemental health services at any time without affecting my right of future care or treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. However, I do understand that due to the COVID-19 national emergency I may not be able to receive certain health and wellness consultation services due to mandates and recommendations prescribed by federal and state authorities.

BY PARTICIPATING IN TELEMENTAL HEALTH SERVICES WITH THE COUNSELING AND PSYCHOLOGIACAL SERVICES CENTER I ACKNOWLEDGE THAT I HAVE READ THIS AUTHORIZATION AND CONSENT FOR TELEMENTAL HEALTH SERVICES FORM AND THAT I UNDERSTAND THE RISKS OF PARTICIPATING IN TELEMENTAL HEALTH SERVICES WITH THE UNIVERSITY. I FURTHER ACKNOWLEDGE THAT I AGREE TO THE TERMS AND CONDITIONS EXPRESSED IN THIS ACKNOWLEDGMENT. FURTHERMORE, I FURTHER REPRESENT AND WARRANT THAT I AM COMPETENT TO AGREE TO THESE TERMS AND CONDITIONS KNOWINGLY AND VOLUNTARILY.

Client Name: _____
(Print)

Signature: _____ Date: _____
(Patient)