San Francisco State University (SF State)
Peggy H. Smith Counseling Clinic (PHSCC)
1600 Holloway Avenue, BH 117
San Francisco, CA 94132
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Addendum: Telebehavioral Health (TBH) Informed Consent

I _____ hereby consent to engage in telebehavioral health (e.g., using Zoom video or Zoom audio -based therapy) via SF State's Peggy H. Smith Counseling Clinic (PHSCC) as a response to the nationwide COVID-19 health concern and the need to provide services remotely for a short time. This document is an addendum to the SF PHSCC standard Consent for Counseling and does not replace it. All aspects of informed consent for treatment in that document apply to TBH treatment. I understand that TBH includes the practice of mental health individual sessions, psychoeducation, consultation, transfer of mental health data, using interactive audio, video, and/or data communications. I understand that TBH also involves the communication of my mental health information, both orally and visually, to other mental health practitioners.

I understand that I have the following rights and responsibilities with respect to TBH:

1) I understand that TBH services require that I must be physically located in California for the duration of TBH services.
2) I understand that TBH requires that I have a quiet, private space free of distractions along with a good, secure internet connection and a computer, tablet or smartphone.
3) I understand it is important to be on time and if I need to change or cancel an appointment, I must call 415-338-1024 to make those changes in advance.
4) I understand that in order for a TBH session to occur I will be asked to identify my current location, one emergency contact and the closest emergency room at the beginning of each appointment in the event that locating me is needed for a crisis situation.
5) I have the right to withhold or withdraw consent to TBH at any time without affecting my right to future care or treatment.
6) I understand that in order to receive TBH services, my counselor's supervisor may audio or video conference during the session in order to oversee my counselor in trainings work. I will be informed ahead of time if a supervisor chooses to video conference during one of the sessions to directly observe my counselor in training's work. In addition, my counselor in training may record individual sessions through video conferencing or audio format. Recordings will be destroyed after review by the supervisor and appropriate documentation of the session.
7) If an in-office intake was not possible, I understand that the counselor in training with whom I meet through TBH will do some basic assessment over Zoom video or Zoom audio in order to assess for possible contraindications of using TBH services, including, but not limited to:
   a. Recent suicide attempt/s, psychiatric hospitalization/s, or evidence of active psychosis
   b. Moderate to severe alcohol and/or drug abuse
   c. Severe eating disorders

d. Repeated “acute” crises

8) CONFIDENTIALITY: The laws that protect the confidentiality of my mental health information also apply to TBH. As such, I understand there are circumstances in which PHSCC is AUTHORIZED or REQUIRED by law to disclose information outside of PHSCC include, but is not limited to: reporting child, elder, and dependent adult abuse; imminent danger to self; expressed and imminent threats of violence towards an ascertainable victim; gravely disabled and in a legal proceeding when there is a court-order to release information. I also understand that the dissemination of any personally identifiable images or information from the TBH interaction to researchers or other entities shall not occur without my written consent.
9) I understand that there are risks and consequences from TBH. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my counselor, that: the transmission of my mental health information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner. In addition, I understand that TBH based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my counselor believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a counselor in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve and in some cases may even get worse.
10) I understand that I may benefit from TBH, but results cannot be guaranteed or assured. The benefits of TBH may include, but are not limited to: finding a greater ability to express thoughts and emotions, increased engagement, and continuation of care with a trusted provider.

I have read and understand the information provided above. I have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

Name of client (First, Last): _____ Student ID: _____

Signature of Client: _____ Date: _____

If client is unable to sign in person,
verbal consent was provided to: _____ Date: _____

Signature of Counselor: _____Date: _____

Signature of Supervisor: _____ Date: _____