WCU
WEST CHESTER
UNIVERSITY

Community Mental Health Services
Wayne Hall 8th Floor
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West Chester, Pennsylvania 19383
610-436-2510 | fax: 610-436-2929
cmhs@wcupa.edu

INFORMED CONSENT FOR TELETHERAPY

This agreement contains important information about teletherapy, which is therapy provided via cell phone, landline, or video teleconferencing over an internet connection. It is important that you read it carefully before agreeing to these terms. Your clinician will answer any questions you have.

TELETHERAPY SERVICES

Teletherapy is offered to patients to increase access to clinic services. Conducting therapy via phone or video teleconferencing changes the method in which we communicate during the therapy session, but it does not change the way therapy is conducted.

Before you agree to teletherapy, it is important to consider the following:

1. We do not want finances to prevent anyone from getting the care they need. For this reason, fees will be waived for therapy services provided while the clinic is closed. This does not apply to balances due for psychological testing completed prior to the clinic's closure.
2. Your sessions should be scheduled during a time when you can be in a quiet, private location that is free of distractions. This will ensure your privacy and create an environment conducive for effective therapy.
3. Your cell phone should not be a source of distraction during the session. Notifications or other alerts that may interrupt your session should be turned off prior to the start of the session.
4. Confidentiality and privacy rules still apply for teletherapy services and, unlike clinic sessions, your teletherapy sessions may be recorded for training/supervision purposes. You will be informed of recording prior to the start of the recording.
5. Teletherapy introduces risks that differ from in-person sessions. These include the possibility of confidentiality breaches due to the use of technology. No electronic technology is 100% secure. Every effort has been made to protect your privacy, and you should know that there is a small risk of breach of privacy when using technology.
6. Successful teletherapy requires access to equipment and software necessary for teletherapy. In addition, your ability to troubleshoot technical problems, with guidance from your clinician, will be important. You should have access to a webcam or smartphone for sessions.
7. We will need a back-up plan (e.g. phone number where you can be reached) to restart the session or to reschedule it in the event of technical problems that can't be resolved during the session.
8. You should have access to a secure Internet connection. We strongly advise against using public or free Wi-Fi for teletherapy sessions.
9. It is important to be on time for your sessions. If you need to cancel or change your teletherapy appointment, you must contact your clinician via their West Chester University email or the Clinic email

(CMHS@wcupa.edu) at least 24 hours in advance. If notice is not given within this timeframe, you may be subject to the No Show or Late Cancellation fee. The Clinic reserves the right to terminate services after excessive no show or late cancellations.

10. Parents or legal guardians must provide written permission for participation in teletherapy when the client is a minor, under the age of 14, when the minor is physically in Pennsylvania. In cases where the client is 14 or older AND is physically in PA, parental permission is not required.
11. In the event of a clinical crisis situation, we need a plan that includes at least one emergency contact, your location and the closest hospital emergency department to your location. We will not begin teletherapy until we receive this information.
12. During the course of a session, your clinician may determine a need to consult with his/her clinical supervisor if safety concerns arise. This consultation may include a text message or phone call consultation during the session or a request that the supervisor join the therapy session to conduct a safety assessment.
13. During the course of treatment, your clinician and their supervisor may determine that, due to certain circumstances, teletherapy is no longer appropriate. In this case, you will be provided with appropriate referrals for care.

Community Mental Health Services does not offer On Call or Crisis Services. Patients who are experiencing a crisis in between teletherapy sessions are encouraged to follow your Safety/Crisis Plan if one has been created. We also encourage you to access the following resources:

Valley Creek Crisis, Exton, PA, (610) 280-3270 – available 24 hrs/day
Crisis Text Line: text: 741741
National Suicide Prevention Line: 1-800-273-8255
Call 911 or go to your nearest hospital emergency department

AGREEMENT TO TELETHERAPY

By signing below, I acknowledge that I am aware of the benefits, risks and responsibilities of engaging in teletherapy through Community Mental Health Services at West Chester University and that I wish to proceed with teletherapy at this time. I may withdrawal my agreement for teletherapy services at any time and my therapist and his/her supervisor reserve the right to terminate teletherapy services and provide me with a referral for services with another provider.

SUMMARY OF PATIENT RESPONSIBILITIES

As a patient of the WCU Community Mental Health Services, I agree to the terms of teletherapy outlined in this consent form. My signature below indicates that I have read this agreement and agree to its terms.

These matters have been explained to me and I fully and freely give consent to receive clinic evaluation and/or treatment services.

_____

Name of Patient(s) Please Print

_____ _____

Signature of Patient(s) and/or Minor Child (under 14 yrs.) **Date**

_____ _____

Signature of Legal Representative of Minor Child **Date**

_____ _____

Signature of Clinician **Date**

Email Communication Consent:

The clinic closure changes how quickly and efficiently we are able to communicate with our clients. At this time, clinicians and clients will be permitted to email. You may still leave messages at the Clinic but be aware that we may not be able to respond to this communication promptly. Email is NOT to be used to provide therapy services or for crisis needs.

By signing below, I give consent for my clinician to send email to me and accept emails from me for administrative purposes only. *Emails will not contain clinical information and are solely for administrative purposes such as scheduling, canceling or changing teletherapy appointments*.

_____ _____

Client Signature preferred email (please write clearly)

_____ Date of Signature

PATIENT TELETHERAPY CONTACT INFORMATION

Please provide this information prior to starting our teletherapy sessions. Your contact information will be used if we experience a disruption in our connection during session so that we may continue the session or reschedule. This information will also be used to ensure your safety in the event of a clinical emergency during our session.

Patient Name:

_____

Patient Telephone Number: _____
(cell/home/work)

Patient Alternate Number: _____
(cell/home/work)

Patient physical address during therapy sessions:

_____

_____

County: _____ Township: _____

Person(s) who may be in the home/location when Patient is in session:

Name: _____ (contact in crisis? Y/N)

Relationship: _____

Phone: _____

Name: _____ (contact in crisis? Y/N)

Relationship: _____

Phone: _____

Name: _____ (contact in crisis? Y/N)

Relationship: _____

Phone: _____

Person(s) who may be contacted during crisis (if different from above):

Name: _____

Relationship: _____

Phone: _____

Address: _____

_____

Nearest Police Station:

Name: _____

Address: _____

_____

Phone: _____

Nearest Hospital with Emergency Services:

Name: _____

Address: _____

_____

Phone: _____

Local Crisis Response Team:

Name: _____

Address: _____

_____

Phone: _____

Local emergency number can be obtained by entering the address into the following internet site: http://www.usacops.com.