Informed Consent for Personal Counseling
East Texas Baptist University Counseling Care Center

I, _____, have voluntarily decided to seek personal counseling from the ETBU Counseling Care Center. I understand the following points about the treatment I will receive:

1) The treatment that I receive is considered confidential. I have been informed about the exceptions to confidentiality and presented with a full copy of the Counseling Care Center's confidentiality policy.
2) Services are provided primarily by graduate trainees and when a graduate trainee is not available, staff members who are licensed counselors. I understand that the Counseling Care Center is a training clinic for students who are completing their Masters in Clinical Mental Health and as such, my counseling sessions will be either conducted by the counseling intern or observed by the counseling intern. I will be informed if I am being seen by a graduate trainee as well as the identity of his/her supervisor. Staff member credentials are kept on file and I may request to view those of my counselor.
3) The Counseling Care Center, among its functions, serves as a teaching-training center for Masters-level graduate students. Each student is individually supervised by a professional staff member and includes recording the counseling session. The supervision and recording of the session, in part, allows us to see that every client is being provided with competent counseling.

Supervision: I understand that _____ (full legal name of the counselor-in-training) is currently completing their Masters of Arts in Clinical Mental Health Counseling degree at East Texas Baptist University. To improve his/her skills, he/she is required to complete a practicum and two internships. The counselor-in-training is currently under the supervision of **_____.** Site supervisors are required to have a minimum of a master's degree, preferably in a counseling, or related profession with relevant certifications and/or license; a minimum of two years of pertinent professional experience; knowledge of ETBU's counseling program requirements, expectations, and evaluation procedures; and relevant counseling supervision training.

4) The staff member who provides my personal counseling will offer treatment that is within the scope of his/her competence to provide.
5) Treatment will be based upon the specific issues, concerns, or problems which the staff member and I agree to work on.
6) Treatment goals are therapeutic in nature. If I have issues that have resulted in court-ordered counseling, have legal implications, and/or require formal evaluation, then I will be referred to off-campus mental health professionals for relevant services.
7) No formal diagnosis will be made by the staff member.
8) The treatment will consist of methods (strategies, techniques, and interventions) that are generally accepted in the mental health field as appropriate for the problems that I present. When there are limitations or foreseeable harm that could occur with a specific method, the staff member will explain them to me.
9) The staff member believes the proposed treatment can improve my condition and enable me to achieve my goals but he/she cannot guarantee the results.
10) The staff member may recommend that I complete a psychological test/inventory as a component in my treatment. He/she will explain the purposes and uses of the test(s). I may choose whether to take them. The staff member will provide an interpretation of the results for any test that I complete.
11) There is no direct charge or cost for treatment services.
12) I, as the client, will not be forced to continue with the proposed treatment. I can choose to discontinue my personal counseling at any time.
13) I have been presented with the "ETBU Counseling Center Confidentiality Policy" sheet that defines other pertinent information about practices and procedures.

Electronic Transmission of Information:

I, the undersigned, agree to participate in technology-based consultation and other healthcare-related information exchanges with _____, a behavioral health care practitioner ("practitioner").

This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application:

It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application" (abbreviated as "app").

I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

Equipment:

I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:

I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

Tele-behavioral Health Process:

My health care practitioner has explained how the tele-behavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Additional Services:

I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other health care providers.

Electronic Presence:

In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" will be transmitted electronically to and from myself and my practitioner.

Limitations:

Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

I understand that tele-behavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.

Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.

Release of Information:

I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

Discontinuing Care:

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners.

I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.

I acknowledge, however, if I withhold information, I assume the risk that my treatment may not be as effective.

Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Upon consideration of the information presented to me, I authorize the staff member to provide me with personal counseling and to use the methods that he/she believes clinically appropriate. I make this decision to accept the proposed treatment knowingly, voluntarily, and without coercion.

Signed: _____ Date: _____