San Francisco State University (SF State)
Counseling & Psychological Services (CAPS)
1600 Holloway Avenue, SSB 205
San Francisco, CA 94132
Phone: (415) 338-2208 Fax: (415) 338-6147

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 CAPS 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 State CAPS 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, group sessions, psychoeducation, consultation, case management, 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 415-338-2208 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) If an in-office intake was not possible, I understand that the counselor 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

7) 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 CAPS is AUTHORIZED or REQUIRED by law to disclose information outside of CAPS include, but is not limited to: reporting child, elder, and dependent adult abuse; danger to self; expressed threats of violence towards an ascertainable victim; and in a legal proceeding when there is a court-order to release information. (See also CAPS Policies and Privacy Practices forms for more details of confidentiality and other issues.) 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.
8) CONFIDENTIALITY for those engaged in GROUPS: I understand that video conferencing technology for groups poses more risks to my confidentiality than do in-person services. My CAPS group leaders are unable to guarantee the privacy of the meeting space or appropriate use of technology of each group member. For example, privacy could be interrupted by the housemate or family member of a group member and this could cause a breach in my confidentiality. I am willing to take this risk and will not hold CAPS liable for a breach of confidentiality that is outside of their control.
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: _______________