THE UNIVERSITY OF ARIZONA CAMPUS HEALTH SERVICE ("CHS") AND COUNSELING & PSYCH SERVICES ("CAPS") CONSENT FOR TELEMEDICINE/TELEBEHAVIORAL HEALTH SERVICES

Telemedicine and/or telebehavioral health is the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation. Your telemedicine and/or telebehavioral health visit will be similar to a routine office visit, except that interactive technology will allow you to communicate with our team at a distance.

As part of my decision to utilize CHS/CAPS Telemedicine or Telebehavioral health services:
Please read the following in full before signing:

1. I understand that my health care provider has invited me to engage in a telemedicine and/or telebehavioral health visit via Zoom, a secure and HIPAA compliant video conferencing platform, or by phone.

2. I understand there are potential challenges to this format, including, but not limited to: (1) unexpected interruptions; (2) unauthorized access or eavesdropping; (3) technical difficulties; and (4) that some individuals may find remote visits less satisfying.

3. I understand that there are potential benefits to this format, including but not limited to: (1) convenience; (2) flexibility; (3) easing social or health concerns; and (4) that the treatment outcomes are the same.

4. I understand that I have alternatives to a telemedicine and/or telebehavioral health visit, including, but not limited to: (1) a list of self-help resources; (2) list of community providers; and (3) an in-person visit, if feasible.

5. I understand that I am only eligible for a telemedicine and/or telebehavioral health visit if I am physically in the state of Arizona, due to state licensing requirements. If I am out of the state of Arizona, I can receive a brief consultation visit (to check in, obtain guidance about resources, etc.). I also understand that some prescriptions for controlled substances cannot be filled across state lines.

6. I understand that neither myself nor my provider will record any of my telemedicine and/or telebehavioral health visits without specific, separate consent.

7. I understand that if I am under the age of 18, CHS/CAPS will need the written permission of my parent or legal guardian (and their contact information) for me to participate in this format.

8. I understand that prior to my first visit, I must provide to my provider at least one emergency contact and their phone number in the event my provider is concerned about my imminent safety and is not able to reach me. If my provider is unable to reach my emergency contact and my provider continues to be concerned about my imminent safety, local police may be contacted to request a welfare check. At the beginning of each video conference visit I may need to confirm my identity by showing my CATCard or other official photo identification. If contact is by telephone, I will confirm my name and student ID number.

9. I understand that telemedicine and/or telebehavioral health may not be suitable for emergency services. If I am experiencing an imminent emergency, I understand that I should call 988 or 911 or proceed to the nearest hospital emergency room for help.
- If I am having suicidal thoughts or making plans to harm myself, I may also call the National Suicide Prevention Lifeline at 988 for free 24-hour hotline support.

- If it is after CAPS business hours, I may choose to call either of the CAPS front desk numbers and press 1 to talk to an afterhours crisis and access specialist for support (CAPS Main 520-621-3334).

10. I understand that the consumption of alcoholic beverages or use of illicit drugs during my sessions is not permitted and that my session will be terminated if I am under the influence of alcohol or drugs.

11. I understand that I need to select a location for my sessions that is quiet, private, and sufficiently well-lit to allow my provider to easily see my face during the visit.

12. I understand that I must have access to a webcam and microphone via a computer, tablet, or smart phone. I am aware that sometimes technology fails to perform to an appropriate standard. If provider is unable to reach me by video within the first few minutes of a scheduled session or loses connectivity during a visit, he or she will call me on the designated back up phone number that is on file. I understand that my provider or I can discontinue the telehealth visit if they determine that the videoconferencing connections are not adequate for my situation.

13. I understand that I will need to notify my provider in advance if I plan to include the presence of another individual in the visit. I or my provider will have the right to request the following: (1) omit specific details in discussion of topics that are personally sensitive to me, (2) ask the individual joining the visit to leave if they are disruptive or not conducive to the effectiveness of the visit, and/or (3) terminate the visit at any time

14. I understand that I can ask my provider any questions about using this format for my visits. I can do this by sending a secure message to my provider via PatientLink (health.arizona.edu/patientlink > Messages > New Message option), by phone (520-621-9202), or during my Zoom telehealth visit.

15. I understand that in certain circumstances, I may also be asked to give verbal consent for my telehealth visit at the beginning of my telehealth visit or prior to my scheduled telehealth visit by phone.

Duration of consent, right to refuse/revoke consent

This consent will not expire. I have the right to revoke this consent at any time by notifying your provider with a written revocation before the expiration date subject to the right of any person who acted in reliance on the consent prior to receiving notice of the revocation. See section 14 for how to contact your provider, or contact CHS Support Services at 520-621-9202

Patient Consent

I have read and understood the above information regarding the use of telemedicine and/or telebehavioral health services, have discussed it with my **counselor/healthcare provider**, and all my questions have been answered to my satisfaction. I understand that I have access to a copy of this Consent Form from CHS. I understand that by signing this Consent Form, I hereby given my informed consent to participate in telemedicine and/or telebehavioral health visit under the terms described herein.

_____ _____

Signature of Patient or Person Authorized to Consent Date

_____

Print Name

F-TELECONSENT 1/2023