Oregon TECH
Integrated Student Health Center

(Mark One) I am enrolled at the:
☐ Klamath Falls Campus
☐ Portland Metro Campus

Telehealth Informed Consent (Video Conferencing)

Introduction of Telehealth: Telehealth is the delivery of mental health support services using video or audio technologies between a provider and a client who are not in the same physical location.
Software Security Protocols: Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. ISHC is utilizing a HIPAA-compliant license for Zoom in order to minimize these risks to the best of their ability.
Technology Backup: In the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. If the video technology is not working, my provider will call me on the telephone number that I have provided here: ____
Self-Termination: I may decline any telehealth services at any time without jeopardizing my access to future care, services, or academic standing.
Modification Plan: My provider and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of telehealth and modify our plan as needed.
Provider Communication: My provider may utilize alternative means of communication as follows:

- S/he may send me a secure message through the ISHC Student Health Portal
- I may be contacted by ISHC staff regarding coordination of appointments
- If I have questions or need to contact my provider, I will call 541-885-1800 and they will be the liaison.

Confidentiality: It is my responsibility to maintain privacy on the client end of communication. The extent of confidentiality and the exceptions to confidentiality that are outlined in the ISHC Informed Consent still apply to telehealth. Please speak with your provider about questions regarding confidentiality.
No Show/Late Reschedule Fees: ISHC employs standard No Show/Late Reschedule Fees in the event that a client does not participate in a scheduled appointment or reschedules within 8 hours of the appointment, because this takes up time that another client could have been seen. For Counseling, you will be charged $25 the first two consecutive times that this occurs; after that, the fee will double for each subsequent instance (up to $300 each). For Psychiatric No Shows/Late Reschedules, you will be charged $295 for intake and $95 for follow-up appointments. If you are unable to keep your appointment, please cancel or reschedule at least 8 hours prior to your scheduled time by calling 541-885-1800 or doing so in the secure health portal.
Documentation:

- My session with my telehealth provider will not be recorded.
- Documentation (i.e. chart notes) will be stored on the private server of the ISHC electronic medical records software, Point and Click Solutions.

Laws & Standards: The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements or documentation of informed consent.
Emergencies:
Assessing and evaluating threats and other emergencies can be more difficult when conducting telehealth than in traditional in-person therapy. Should your counselor believe that you are in crisis, they will take steps to establish support for you in your location. By providing the contact information below, you are authorizing ISHC to contact this person in the event of a crisis. If you are in need of immediate and urgent assistance go to your nearest emergency room; you can also call the suicide hotline at 988 or text HOME to 741741.

Emergency Contact Name: _________________________________ Relationship to You: ________________

Cell Phone Number: _________________________ Other Phone Number: ____________________________

I have read and understood this information. I hereby give informed consent to use telehealth in my mental health care.

____ ___________________
Signature of Client Date

____
Printed Name