GCU Office of Student Care
Video & Teletherapy Consent Form
3300 W Camelback Rd
Phoenix, AZ 85017

CONSENT FOR VIDEO & TELETHERAPY DISCLOSURE & INFORMED CONSENT

Patient Name ____ Date of Birth ____________________

Please read the following video and teletherapy consent and sign below. If mutually agreed upon between you and your Student Care therapist, your treatment may include diagnosis, consultation, transfer of medical data, and education using interactive telecommunications video/audio technology. This involves the communication of your medical and mental health information, both orally and visually, to your Student Care therapist. Some information may be communicated by email with your therapist regarding consent, appointment information, or providing additional resources, but will not consist of any clinical content.

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seeks to communicate with patients, and provide telehealth services, through remote communication technologies. These technologies, and the manner in which they are used by HIPAA covered health care providers, fully comply with the requirements of the HIPAA Rules.

For these services, we will be utilizing Zoom for video and teletherapy sessions. Please be aware that it is your responsibility to take steps to preserve your privacy by using a nonshared computer for video and/or teletherapy sessions, and to use a strong password for your account.

Additionally:

1. I understand that video & teletherapy conferencing technology will not be the same as an in-person session with a therapist due to not being in the same room as my therapist. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.
2. I understand there are potential risks to this technology that include, but are not limited to, interruptions, unauthorized access, breaches of confidentiality, theft of personal information, and disruption of services due to technical difficulties. I understand that my therapist or I can discontinue video or teletherapy sessions if it is felt that the video or teletherapy conferencing connections are not adequate for the situation.
3. I understand that regardless of technology, some information my therapist would ordinarily get through in-person sessions may not be available in video or teletherapy. I understand that such missing information could in some situations make it more difficult for my therapist to understand the issues I am experiencing.
4. I understand that my therapist agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I agree to inform my therapist if there is another person present during the session.
5. I understand that I can direct questions about video or teletherapy sessions at any time to my therapist.
6. I understand that this consent will last for the duration of the fall semester with my therapist. I can withdraw my consent for video and teletherapy sessions at any time, and my therapist will provide additional resources to me.
7. I understand that the same confidentiality protections, limits to confidentiality, and rules regarding my records apply to a video or teletherapy session as they would to an in-person session.

8. I understand that my therapist will not record video or teletherapy sessions. I also agree not to record video or teletherapy sessions.
9. I understand that my therapist and I will regularly assess the appropriateness of continuing to deliver services to me by video or teletherapy services, and modify our plan as needed.
10. I understand that my provider may decide to terminate video or teletherapy services if they deem it inappropriate for me to continue with video or teletherapy.
11. I understand that my therapist may only conduct video or teletherapy sessions with clients who are physically in the state of Arizona.
12. I understand that during the course of the video or teletherapy sessions if my therapist feels that I am in a real or potential crisis that could affect the health or safety of myself or others, my therapist will take the appropriate steps to ensure my safety and the safety of others.
13. I understand that my therapist will inform me of emergency procedures to take in the event my therapist is unavailable.
14. I understand that in the event of an emergency I will call the following numbers based on my county: Maricopa County served by Mercy Care: 800-631-1314 or 602-222-9444; Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties served by Arizona Complete Health - Complete Care Plan: 866-495-6735; Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties served by Steward Health Choice Arizona: 877-756-4090; Gila River and Ak-Chin Indian Communities: 800-259-3449; Salt River Pima Maricopa Indian Community: 855-331-6432.

I understand I may revoke this consent at any time and that upon fulfillment of the above stated purpose, this consent will automatically expire in January 2021 without my expressed revocation.

I have read or had this form read and/or had this form explained to me. I fully understand its contents, including the risks and benefits of video and/or teletherapy.

I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction. I give my consent to participate in video and/or teletherapy sessions with my Student Care therapist.

I understand that I have the right to receive a copy of this authorization if I so request.

Patient Signature ____ Date_____________________