FORM 12-3

DEPARTMENT OF EDUCATION
STUDENT SUPPORT SERVICES DIVISION
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TELEMENTAL HEALTH INFORMED CONSENT FORM

FORM TO BE COMPLETED BY: Parent or Legal Guardian, or Student (18 years or older)

I, _____, hereby provide my informed consent to participate in Telemental health with the School-Based Behavioral Health Services, under the Guam Department of Education, as part of my behavioral health treatment services. I understand Telemental health is the practice of delivering clinical mental health care services via technology assisted media or other electronic means between a Licensed Behavioral Health Counselor and a client/family who are located in two different locations.

I understand the following with respect to Telemental health:

1. I understand I have the right to withdraw consent to Telemental Health at any time without impacting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand there are risks, benefits, and consequences associated with Telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws protect the confidentiality of my protected health information (PHI) also apply to Telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it will be determined Telemental health services are not appropriate and a higher level of care is required.
6. I understand during a Telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, I will end and restart the session. If we or either I or my provider is unable to reconnect within ten minutes, we have to re-schedule the Telemental Health Session to another date and time.
7. I understand my SBBH provider may need to contact my emergency contact and/or appropriate authorities (Guam Police Department, Guam Fire Department, or Guam

Paramedics) in case of an emergency such as suicide or homicide ideations, intents, or plans, physical/sexual abuse, danger to self/others, or acute psychosis.

8. I understand my SBBH session at this time will be at least thirty (30) minutes through Telemental health at least one (1) time a week for at least two months.
9. I understand my SBBH provider will select the type of Telecommunication medium to deliver Telemental Health to me.
10. I understand it is my responsibility as well as my parent (s)/legal guardian to obtain and maintain adequate technology for my SBBH services at my unsupervised setting. I also understand my SBBH provider and the Guam Department of Education (GDOE) are not responsible nor required to provide me or my parents/legal guardian any technology/items/materials for my SBBH services at this time for Telemental Health.
11. I understand if I do not log into the selected Telecommunication (Video and Audio Call) for my session after ten (10) minutes of my scheduled appointment, my session will be counted as a No Show and my session will be rescheduled to the following week.
12. I understand in the event I need to reschedule my session for whatever reason, I will email my SBBH provider (email) at least two (2) hours before my scheduled Telemental Health Session.
13. I understand my provider will not be utilizing his personal cellular telephone for virtual telemental health sessions. I also understand my SBBH provider will not be accepting, receiving, responding, or communicating with me through regular cellular telephone text messages, WhatsApp text messages, Facebook, Twitter, Instagram, Yahoo Messenger, MSN Messenger, or any technological app other than GDOE email address.
14. I and my parent(s)/ legal guardian understand I/we am/are only to contact the SBBH provider by email (email) as a means of communication regarding SBBH services until my SBBH provider has access to a GDOE telephone. Please note email is not secure, so communication should be limited to scheduling questions, providing resources, and supplying any applicable information for your GDOE team meetings.
15. I understand the SBBH provider has at least 72 hours to respond to me by email to my email messages.

Emergency Management Protocols:
The SBBH provider at GDOE does not provide any type of emergency services at this time through Telemental Health. I, _____ (client) am required and I agree to provide my current location of my unsupervised setting in case of an emergency to my licensed SBBH provider at the beginning of each session. I will also provide a contact person who my licensed provider may contact on my behalf in a life- threatening emergency. This person will only be contacted to go to my location and take me to the nearest medical hospital (Guam Memorial Hospital or Guam Regional Medical City) in the event of an emergency. In case of an emergency, my location is: _____ and my emergency contact person's name, address, and telephone number:
_____.

Acknowledgement and Release of Liability:
By signing below, I have acknowledged I have fully reviewed, understand, and agree to the terms and conditions of this Telemental Health Informed Consent Form. I have discussed such terms and conditions with my SBBH Provider and I understand the information contained in this form and all of my questions have been answered to my satisfaction. I agree and I provide my written informed consent for conditions for items 1 to 15 above. Moreover, in consideration of the benefits to be derived from the Telemental Health counseling, I hereby release all legal liability to this licensed SBBH Provider (Clinician Name) and GDOE from any and all claims,

demands, damages, actions, or causes of action whatsoever related to the TeleMental Health counseling.

_____ _____

Signature of Client / Date Signature of Parent/Legal Guardian/ Date

_____

Signature of Provider / Date

□ Form was reviewed/discussed with client and parent/legal guardian via video and audio conference and will sign upon next physical contact.