TAMU Psychology Clinic
Department of Psychological & Brain Sciences
College of Liberal Arts

Consent to Telebehavioral Health (Audio only or Audio-Video) Services – Adult Client or Parent/Guardian Consent

By signing below, I, _____ _____
understand and agree: *(print name of Adult Client or Parent's/Guardian of Child Client)* *(Date of birth)*

- Telebehavioral Health services (audio only or audio-video tele-appointments) have benefits. For example, I can continue services when unable to leave my home or safely travel to the Clinic. Also, some risks exist, for example, depending on where I am located, my tele-appointments may be less private compared to in-person appointments in the Clinic and the quality and reliability of a connection can be poor during tele-appointments.

- My tele-appointments have the same limits of confidentiality described in the original consent for services I signed. For example, if I (or my child who is the client) become an immediate danger to myself or to others, Clinic staff will include other people to develop a safety plan, including the Emergency Contacts I listed in the Informed Consent for Specific Situations form.

- I will plan with my therapist about what to do if my internet, Wi Fi, or telephone connection becomes disconnected or poor during a tele-appointment. I will NOT audio or audio-video record any part of my tele-appointment.

- **Minor Children Clients Only:** I give my permission to provide tele-appointment services directly to my child.

_____ _____
(print Minor Child's name) *(date of birth)*

  - I am required to be present or near-by, during tele-appointments with my child and provide an alternate way to be reached if our internet, Wi Fi, or telephone connection is poor or disconnected.
  - I may discuss whether or not tele-appointments are effective or appropriate, given my child's age, developmental level, or other specific aspects of my child or the services she/he needs.

- If my therapist and his/her faculty supervisor decide that tele-appointments are not appropriate or advised for me, I will discuss this with my therapist and plan for options available.

- I need to be in a quiet, private room (NOT a moving vehicle) without distractions and on-time for my tele-appointments. I will NOT use a speaker-phone or other loud speaker function and will consider using earbuds or headphones so that others in nearby rooms cannot overhear me.

- I will not be charged for an initial tele-services set-up appointment. If my therapist and I decide to meet further for tele-appointments, the Clinic will charge and collect fees from me at the rate agreed to for in-person services.

- If I need to cancel or change my appointment time, I will call 979-845-8017. As with in-person appointments, to avoid failure-to-cancel fees, the Clinic requires a telephone call from me to cancel or reschedule a session TWO (2) hours or more before my scheduled appointment.

- I can withdraw my consent for tele-appointment services at any time by speaking or writing to my therapist.

_____ _____ _____ _____
Print Client or Parent/Guardian Name to Represent Signature | Date | Therapist/Evaluator's Signature | Date

_____ _____
Faculty Supervisor's Signature | Date

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Mailing Address
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