



## **Informed Consent for Group Telehealth Services and Waiver of Liability**

### **Group Telehealth Services**

The UIndy Student Counseling Center (“We”, “we”, “Our”, “our” or “us”) is currently using Google Meet for group telehealth services. This system meets Health Insurance Portability and Accountability Act (“HIPAA”) standards of encryption and privacy protection, but we cannot guarantee privacy. You will not have to purchase a plan to use this program, as it is accessible through your UIndy email (Gmail) account. We reserve the right to change the telehealth platform we use at any time based on new information. You will be informed of any changes that occur. We offer support groups, workshops, and therapy groups. For simplicity, all group services will be referred to as “group” unless otherwise specified.

#### *1. Confidentiality*

Our personal commitment to maintaining confidentiality remains the same as stated in our Informed Consent for Telehealth Services form, which also indicates that our exceptions to confidentiality include: 1) We have reason to believe you are at an immediate risk of harm to self or others; 2) We have reason to believe a child or dependent adult, such as an older adult or person with a disability, is, or has been, in danger of physical, sexual, or emotional neglect or abuse; and 3) Legal mandates.

Because of the risks associated with using technology, however, we have a decreased ability to fully guarantee confidentiality of your information. To do our best, we are using a HIPAA compliant platform, will engage in group telehealth services over a secure internet connection, and ensure our computers have anti-virus protection. We encourage you to take the same precautions to protect your information.

#### *2. Potential Benefits to Group Telehealth Services*

Telehealth services have potential benefits including easier access to care, continuity of care, increased social connection, and the convenience of meeting from a location of your choosing.

Additional benefits to group telehealth services may include comfort in knowing you are not alone and that others have similar concerns or sources of stress, the opportunity to gain perspectives from multiple people rather than from one individual counselor, consistent and weekly meetings, and increased motivation to reach your goals due to a sense of accountability one might feel as a group member as well as receiving support from multiple people.

#### *3. Potential Risks of Group Telehealth Services*

There are potential risks to this technology, including interruptions, unauthorized access or breaches of information, and technical difficulties, which cannot be predicted or fully controlled.

As with any therapy, we cannot make guarantees about the results of the telehealth services. People may also have increased difficulty reading non-verbal cues and knowing when to speak in order to avoid interrupting others. Please be patient with the facilitator and other group members in this process.

#### *4. Voluntary Participation and Termination*

You should not participate in group telehealth services other than on a voluntary basis. You have the right to withdraw from the group telehealth services at any time. We ask that you inform the group facilitator if you no longer plan to attend the group.

#### *5. Referral to Alternative Resources*

If the group facilitator or your individual counselor determine that group telehealth services are inadequate for the situation and your needs, we reserve the right to either connect you to our individual counseling services or provide you a list of services available in your community.

#### *6. Request for Feedback*

In order to maintain high quality group telehealth services, we may ask you to complete an anonymous evaluation of the group you attended. While your completion of this evaluation is voluntary, your input would be greatly appreciated.

### **Your Responsibilities as a Group Participant in Telehealth Services**

1. You must use a secure (non-public) internet connection to participate in the group.
2. Recording of the telehealth group meeting by members is strictly prohibited. It is your responsibility to disable computer and device-generated recording. You may be subject to legal action by group members if you create or share any audio or video recordings of group meetings. Should the facilitator need to record the session for supervision purposes, that person will first obtain the written consent of all participants.
3. In order to maintain the group's privacy, it is important to connect from a quiet and private room with no interruptions or distractions from people or other devices. It is imperative that no persons, other than yourself, are in hearing or visual proximity to you during the group meeting.
4. Although guarantees cannot be provided by the group facilitator(s), group members must agree to maintain the confidentiality of other group members. This means that you may not disclose names or other identifying information about group members, nor may you discuss the personal issues and experiences of other members. This includes, but is not limited to, written posts and pictures on social media forums. Discussing your own experience of being in the group with non-members is acceptable.
5. It is important that group members arrive on time for the group meeting to minimize disruptions. If you are signed up for a workshop, please notify us by either calling the UIndy Student Counseling Center or emailing the group leader at least twenty-four (24) hours in advance if you cannot attend.

6. If at any point you are experiencing thoughts of suicide or homicide, it is your responsibility to contact our office to request to speak with an individual counselor or, if it is after business hours, to contact a crisis line (1-800-273-8255) or 911.

If you make comments during the group meeting suggesting suicidal thoughts, homicidal thoughts, or abuse or neglect of a child or dependent adult, please be aware that a counselor may follow up with you after the meeting has ended to ask additional questions about these disclosures in order to assess the current level of risk. You may be contacted after the group for follow-up by: 1) the group facilitator, and/or 2) your individual counselor upon notification by the group facilitator. If we cannot reach you and suspect you might be at risk of harm to yourself or others, we reserve the right to communicate with your emergency contact or request a wellness check by the local police in your area.

### **Release, Waiver and Hold Harmless**

By signing below I hereby release and discharge the University of Indianapolis, its Trustees, officers, employees, therapists, Clinical Students, students, volunteers, agents and assigns (the “Released Parties”) from any and all claims which may arise from any cause whatsoever in connection with my participation in these group telehealth services. I further release the Released Parties from any liability for any accident, illness, injury, death, loss or damage to personal property, or any other consequences arising or resulting directly or indirectly from my participation in the group telehealth services. I acknowledge the Released Parties assume no responsibility for any liability, damage, injury or death that may be caused by my negligent or intentional acts or omissions committed prior to, during, or after participation in the group telehealth services, or for any liability, damage, injury or death caused by the intentional or negligent acts or omissions of others. I agree to indemnify, defend, and hold harmless the Released Parties from any injury, loss or liability including reasonable attorneys’ fees and/or any other associated costs, from any action, claim, or demand in connection with my participation in the group telehealth services.

### **Consent for Group Telehealth Services and Authorization**

By completing and signing this consent form:

1. I confirm that I have read and fully understand the above, I have contacted the UIndy Student Counseling Center with any questions I have and all of my questions have been answered to my satisfaction. I further agree to adhere to the responsibilities contained herein.
2. I authorize UIndy Student Counseling Center counselor(s) to allow us to meet via a telehealth platform and to send Google Meet invites and group/workshop materials to my UIndy email account. I am aware that there may be additional charges from my internet and/or phone provider and I do not hold the University of Indianapolis accountable for those charges.
3. For the purposes of maintaining the safety of myself and others, I consent to provide my phone number, email address, physical address at which I connect to services, and an emergency contact.

*Signatures on next page*

Student Name: \_\_\_\_\_

UIndy Student ID: \_\_\_\_\_

Student Phone Number: \_\_\_\_\_

Student UIndy Email Address: \_\_\_\_\_

Address Where You Plan to  
Engage in Telehealth Services: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Student Electronic Signature (Type Name): \_\_\_\_\_

Today's Date: \_\_\_\_\_

**For Minors Only**

If the person participating in the these group telehealth services is not yet eighteen (18) years old, both parents or the legal guardian(s) must sign below:

In exchange for my/our child or ward being allowed to participate in the group telehealth services and as the parent(s) or legal guardian(s) of the above-named individual, I/we verify that I/we fully understand, agree to, and accept all provisions of this Informed Consent for Group Telehealth Services and Waiver of Liability.

_____	_____	_____
Printed Name (Parent or Legal Guardian)	Signature	Date

_____	_____	_____
Printed Name (Parent or Legal Guardian)	Signature	Date