CAL STATE EAST BAY

Informed Consent to Receive Psychiatric Treatment

The Cal State East Bay Student Health and Counseling Services (CSUEB SHCS) provides psychiatric assessment and medication management to currently enrolled CSUEB students.

During your first appointment, the psychiatrist will complete a psychiatric assessment and provide diagnostic and treatment recommendations. This first appointment is a consultation and does not establish a patient-physician relationship with the psychiatrist. If indicated, medications may be prescribed. Some students may be referred to community providers for treatment outside the scope of care.

Psychiatric treatment is a *medication*-based service and does *not* provide therapy. If you are interested in therapy, you can **schedule an appointment online at https://health.csueastbay.edu, call (510) 885-3735, or email shcscounseling@csueastbay.edu.**

I understand that the psychiatrist does *not* provide urgent or emergency psychiatric evaluations, and that I should use the following resources for urgent mental health issues or emergencies:

- For emergencies, **call 911 or go to the nearest emergency room** immediately.
- Counseling Services has urgent mental health drop-in hours **Monday-Friday, 1-2pm and 3-4pm.**
- When the center is closed, call **(510) 885-3735**, **option 2** to speak with a live counselor.
- Call **988** or **text HOME to 741741** to reach The National Suicide Prevention Hotline

Initials:_____

Confidentiality

I understand that SHCS maintains the highest standards of confidentiality and meets or exceeds all legal and ethical standards in this area. I understand that information received in psychiatry appointments will not be released without my written consent, except in situations dictated by law. I understand that those exceptions include child abuse/neglect, elder and dependent adult abuse/neglect, danger to self or others, or by a specific order of the courts. I understand that the psychiatrist may consult with counselors, medical doctors, nurses, or other SHCS staff as needed to benefit my care. I understand that the psychiatrist will document all clinically relevant information in my chart, including but not limited to, current and past substance use.

I understand that I may rescind my authorization for the psychiatrist to consult with other SHCS staff about my care anytime by informing the psychiatrist verbally or in writing via secure message in My Pioneer Health.

I understand that it is recommended - though not required - that I provide consent for the psychiatrist to communicate with a family member and/or significant other to coordinate my care.
Initials:_____

Communication

I understand that any form of electronic communication (phone, fax, email) is not necessarily confidential, and will only use the student portal to contact the psychiatrist. I understand that notifications of secure messages are sent to my CSUEB Horizon email account and **that if I do not check my CSUEB Horizon email *daily*, I may miss time-sensitive information that could adversely affect my health and treatment.**

I understand that secure messaging is for *non-urgent* issues only and it may take the psychiatrist several business days to reply to my message. **For urgent mental health issues, I will call (510) 885-3735** and dial **option 2** to speak with a counselor. **For emergencies, I will call 911 or go to the nearest emergency room** immediately.
Initials:_____

Telemental Health

Telemental health (TMH) refers to clinical services provided via phone or videoconference, and is offered to provide access to psychiatric services to CSUEB students who are currently located in the state of California but are unable to, or prefer not to attend in-person sessions at the SHCS. TMH services may not be appropriate or the best choice for reasons including, but not limited to: heightened risk of harm to oneself or others; lack of access to, or difficulty with,

communications technology; significant communications service disruptions; location outside of CA; or need for more specialized services. In these cases, the psychiatrist will recommend an in-person visit, or give appropriate referrals. I understand there are risks associated with engaging in TMH, including, but not limited to: sessions could be disrupted, delayed, or communications distorted due to technical failures; TMH involves alternative forms of communication that may reduce visual and auditory cues and increase the likelihood of misunderstanding one another; the psychiatrist may determine TMH is not an appropriate treatment option or stop TMH treatment at any time if my condition changes; if TMH presents barriers to providing appropriate treatment; or, if any of the criteria listed above that outline why TMH may not be appropriate are met; and security protocols could fail and my confidential information could be accessed by unauthorized persons.

I understand that I may only engage in TMH sessions when I am physically located in California. The psychiatrist will confirm my current location at the start of each session. I agree to engage in sessions only from a private location where I will not be overheard or interrupted, and I, nor the psychiatrist, will record any sessions.
Initials:_____

If I show signs that my symptoms are getting worse or that I may be in danger, and I fail to respond to messages, I grant the SHCS permission to contact my emergency contact to verify my well-being.
Emergency Contact Name_____
Emergency Contact Phone_____
Initials:_____

If I show indicators that I may be at serious risk for self-harm or harm to others, I understand that SHCS is required to contact the law enforcement agency closest to me to ensure my safety. Initials:_____

I understand that SHCS cannot provide 24-hour emergency management, particularly if I am using services at a distance. If I am ever experiencing an emergency, including a mental health crisis, I agree to contact one of the following 24-hour emergency resources:

- For emergencies, **call 911 or go to the nearest emergency room** immediately.
- Counseling Services has urgent mental health drop-in hours **Monday-Friday, 1-2pm and 3-4pm.**
- When the center is closed, call **(510) 885-3735**, **option 2** to speak with a live counselor.
- Call **988** or **text HOME to 741741** to reach The National Suicide Prevention Hotline

Initials:_____

<u>Fees</u>
I understand there is no fee to schedule an appointment with the psychiatrist, but I am responsible for the cost of any medication prescribed. If I cannot afford a medication, I can inform the psychiatrist and they will help me find affordable alternatives.
Initials:_____

<u>Medication</u>
During my initial appointment the psychiatrist will discuss medication treatment options, potential side effects, and how to manage them. I understand that I should not share my medication with anyone else or receive psychiatric medications from other providers without first informing the CSUEB psychiatrist.

I understand alcohol and other drugs may compromise my treatment and make my symptoms worse and the SHCS recommends I abstain from these substances while in treatment. Additionally, combing alcohol or opiates with benzodiazepines or hypnotics (like Ambien) is particularly dangerous and can be fatal. I understand that if misuse medications or combine them with other substances, I may be asked to provide a urine drug screen at the SHCS, and that my medications may not be refilled.
Initials:_____

<u>Refills</u>
I understand that if I do not follow-up as recommended, **my medication may not be refilled until my next appointment.** I understand that ADHD (e.g. Adderall) and benzodiazepine (e.g. Klonipin) refills **always require a monthly appointment**, and that if I miss or cancel my follow up appointment, my controlled medication may not be refilled until my next appointment.
Initials:_____

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Missed appointments/Cancellations/Late Arrival

I understand that if I fail to show for a scheduled appointment without notice (no show), or I do not cancel a scheduled appointment at least 24 hours in advance, **I will be charged a $25 no show/late cancellation fee.**

I understand that if I arrive late to an appointment, I may not be seen and my appointment may be rescheduled by SHCS.
Initials:_____

Scheduling

I understand that I must obtain a referral from a SHCS counselor before I can schedule an appointment with the SHCS psychiatrist, and that I cannot schedule or cancel psychiatry appointments online. Once referred, I can schedule a psychiatry intake appointment by calling the SHCS at 510-885-3735 or in person at the SHCS front desk. I will need to give the scheduler the name of the referring counselor.

I understand that I must present a valid form of identification to my psychiatry intake appointment, whether in-person or via telehealth. I understand that the only acceptable forms of identification are: 1) passport, 2) government ID (either driver's license or just ID), and 3) CSUEB Bay Card with photo. I understand that the ID I present must be a hard copy (not a photo or digital copy), valid and active (not expired), and my photo must be clear and recent enough to easily identify me. I understand that if I do not present a valid form of ID as described above, my intake appointment will be rescheduled, and may not be rescheduled for several weeks, depending on appointment availability.
Initials:_____

Limits

I understand that there is no limit to the number of sessions I may receive during the academic year. I understand that the psychiatrist can assess and treat general psychiatric disorders including depression, mania/hypomania, bipolar mood disorder, anxiety, panic attacks, OCD, PTSD/trauma, insomnia. However, there are situations where I may be referred off campus for treatment. These are per the psychiatrist's clinical judgment, and may include but are not limited to:

- Assessment and diagnosis for ADHD, Autism, and other complex diagnostic cases
- Unstable or severe, persistent disorders that require visits more than once per month
- Drug and alcohol withdrawal
- Active eating disorders

I understand that my psychiatric care may be terminated, and I may be referred elsewhere if I do not follow treatment recommendations, including referrals, taking medications as prescribed, following up in the recommended time frame, following up with recommended higher level of care, or not adhering to the patient responsibilities. I understand that I may decline further participation or recommended treatment at any time, and that I can ask that my psychiatry file be closed at any time verbally or via secure message.
Initials:_____

ACKNOLWEDGEMENT:

I agree that this consent form may be electronically signed and that my electronic signature appearing on this consent form is the same as handwritten signatures for the purpose of validity, enforceability, and admissibility. I understand that I can opt-out of signing this document electronically by contacting SHCS. I understand that I may receive an electronic copy of this consent form by requesting it from SHCS and providing my email address and SHCS will email the form to me. If I am unable to receive the form via email, I can notify SHCS and other arrangements can be made.
I have read this description of services and understand and consent to the information presented above. I understand that I can discuss any questions with the SHCS. I understand there are potential risks and benefits associated with psychiatric services. I have the right to make decisions about the psychiatric services I receive, to refuse psychiatric services, and revoke this consent any time. I understand I have an opportunity to discuss questions regarding services with the TMH psychiatrist. I understand that there are potential risks and benefits associated with receiving TMH services. I understand that I have the right to make decisions about the TMH services I receive, to refuse TMH services and to revoke this consent at any time except to the extent services have already been provided. I understand that the psychiatrist may determine that it is not appropriate for me to receive TMH services at any time. In this case, I understand that I will be notified of this decision and will be provided resources for accessing more appropriate mental health services. I consent to psychiatric treatment and TMH services provided by CSUEB SHCS.

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Student printed name_____NetID_____

Student signature_____Date_____