Cowell Center - Counseling and Psychological Services (CAPS)
CONSENT FOR TELEPSYCHOLOGY/TELEPSYCHIATRY TREATMENT

Client Name: _____ **Client Student ID #:** _____ **Date of Birth:** _____

Address where Client Will Be during TPT: _____ **Cell Phone #:** _____

This document is only an addendum to the "SCU Consent for Counseling and Psychological Services" and does not replace it. All aspects of informed consent for treatment in that document apply to this Consent for Telepsychology/Telepsychiatry Treatment (TPT). TPT refers to individual/group sessions and psychiatric services that occur via phone or videoconference using a variety of technologies. These services may also include prescribing medication, scheduling appointments, communicating electronically co