

## TELEPSYCHOLOGY INFORMED CONSENT

As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.
2. If a need for direct, face to face services arises, it is my responsibility to contact providers in my area such as Dr. Rose Mary Shaw, \_\_\_\_\_, or \_\_\_\_\_ or to contact this office for a face to face appointment. I understand that an opening may not be immediately available.
3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.
4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
  - a. In emergency situations  
**Call 911.**
  - b. Should service be disrupted  
**We will contact you directly.**
  - c. For other communication  
**Use Counsel patient portal.**
6. My psychologist may utilize alternative means of communication in the following circumstances:
7. My psychologist will respond to communications and routine messages within  
24 hours Monday - Friday

8. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
9. I will take the following precautions to ensure that my communications are directed only to my psychologist or other individuals:
10. My communications exchanged with my psychologist will be stored in the following manner:
11. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

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Client Printed Name

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Signature of Client or Legal Guardian

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Date

**Rose Mary Shaw, PsyD**

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Printed Name of Psychologist

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Signature of Psychologist

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Date

**Liability Disclaimer:** *The Ohio Psychological Association (OPA) have attempted to provide guidance with this form in line with current laws and guidelines, but the form may need to be tailored to each situation and individual, laws change, and we cannot guarantee freedom from legal liability. It is up to each psychologist to confirm that they are following legal requirements.*

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**Questions?** Contact the Ohio Psychological Association at 614.224.0034.