



24800 Chagrin Blvd. Suite 103  
Beachwood, OH 44122  
Phone: (216) 245-6231  
Fax: (216) 245-6351

## **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 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/therapist 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 emergencies
  - b. Should service be disrupted
  - c. For other communication
6. My psychologist/therapist may utilize alternative means of communication in the following circumstances:

- 
- a. Coordination of services between provider and client
  - b. Coordination of services between provider and third party payers
  - c. Disruption of services.
7. My psychologist/therapist will respond to communications and routine messages within 24-48 hours.
  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/therapist or other individuals:
    - a. Ensure a secure and private environment when conducting telehealth services with my provider.
    - b. In the event that conditions are not secure and private, I will inform my provider and establish a plan of action to improve such conditions.
  10. My communications exchanged with my psychologist/therapist will be stored in the following manner:
    - a. Documentation of data according to my psychologist/therapist's code of ethics, HIPPA laws, and laws of the State of Ohio for the practice of psychology and/or mental health.
    - b. In the event that the chosen telehealth platform (including, but not limited to Zoom, FaceTime) provides storage of data, my psychologist/therapist will inform me of such conditions. I can agree or disagree to the storage of such data, to the extent allowed by law and by the telehealth platform utilized.
  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.

---

Client Printed Name \_\_\_\_\_

Signature of Client or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Psychologist/Therapist \_\_\_\_\_

Signature of Psychologist/Therapist \_\_\_\_\_ Date \_\_\_\_\_