



## TELEPSYCHOLOGY INFORMED CONSENT

1. I understand that I must be an established client receiving services at Tawnya S Foster, Psy.D., LLC to be considered for Telepsychology sessions. Initial assessments are not conducted via video-conference.
2. I understand that Dr. Foster is making use of Telepsychology sessions to address needs for service and to protect patients and the psychologist during possible quarantines and/or safety concerns related to COVID-19. I understand that face-to-face sessions will resume on a regular basis once the Coronavirus crisis is resolved.
3. I understand that in order to participate in Telepsychology sessions, I will need to access a reliable internet connection on a computer or mobile device in a private setting. I will be responsible for making sure that the camera and microphone on my device are accessible to the [doxy.me](https://doxy.me) platform used for Telepsychology sessions. I know that I can request a “set-up” trial with my psychologist to be sure the technology works prior to my scheduled session.
4. I understand that it will be my responsibility to assure privacy for myself/my child during the session. I will inform my psychologist of 1) my location, 2) any other persons in the room with me during a session, and 3) a way that I can be reached by Dr. Foster if we lose the internet connection. I understand that Dr. Foster will be conferencing with me from a private room and will maintain my/ my child’s confidentiality.
5. I understand that in the event of a technology failure during the session, we might have to revert to a telephone session.
6. I understand that my psychologist may choose not to offer Telepsychology services with me, or to cease conducting such sessions, if she deems such sessions to be inappropriate for my circumstances for any reason.
7. I understand that typical session fees, as listed in the Contract and Client Information document, will apply to Telepsychology sessions. If I am using insurance to pay for sessions, claims will be submitted to my insurance company as usual. In the event that my insurance company denies the claims, I understand that I will be responsible for the fees myself.
8. I understand that all other elements of the Contract and Client Information document still apply, in addition to these specifications for Telepsychology sessions.
9. I understand that, in order to participate in a Telepsychology session, I must be physically located in the state of Ohio at the time of the session.
10. I understand that there are benefits and limitations to telepsychology services. 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. 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.

11. I understand that in the event of an emergency I will go to the nearest emergency room or call 911. In a crisis, I can contact the Franklin County Youth Psychiatric Crisis Line at 614-722-1800 (for those 17 and under) or Netcare Access at 614-276-2273.

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Client Printed Name

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Signature of Client or Legal Guardian

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Date

If you are signing this Consent electronically, you agree your electronic signature is the legal equivalent of your manual/handwritten signature on this Consent.

Dr. Tawnya S. Foster

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Printed Name of Psychologist

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Signature of Psychologist

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Date

*If you choose to sign electronically, please download this PDF, fill out the designated areas and email the finished PDF back to Dr. Foster at [dr.tsfoster@gmail.com](mailto:dr.tsfoster@gmail.com). Thank you.*