Mark D. Ackerman, Ph.D.
Licensed Psychologist
2751 Buford Highway
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Psychologist Telehealth Informed Consent

Thank you for considering services for telehealth (e.g., remote) evaluation/treatment sessions. Due to the Covid-19 pandemic, remote sessions may be a helpful component to your evaluation/treatment plan. Telehealth sessions are conducted in a video-conferencing format and require you to have computer access so that we may see and hear each other. They are simple and convenient and reduce the need for you to travel to our office. At times, access to a computer screen may not be available or desired, thus telephone sessions are also an option. You have the choice to discontinue at any time and request an in-office visit.

By signing this agreement, you acknowledge that you have been advised that telehealth sessions are at your request. You are advised that telehealth (e.g., remote) sessions may be unknowingly subject to "hacking" and as a result, cannot be guaranteed to be fully secure or as confidential as a face-to-face treatment session within the office setting. However, my practice will take every possible step to ensure your confidentiality by using a secure, HIPPA- compliant technology platform. By signing this informed consent, you accept that risk and agree herewith your signature below that you will not file a complaint or take legal action in the extremely unlikely event that a hacking or inadvertent invasion of your privacy occurs on the basis of a technological fault such as that mentioned here or in some other form. All telehealth sessions will remain fully confidential and your records from each visit will be maintained in a locked file and will be given the same confidential treatment as applies to standard in-office treatment sessions. All the current standards of psychological practice including professionalism, confidentiality and "duty to warn" will apply to your telehealth sessions. You are also encouraged to contact this office if you have any questions concerning telehealth treatment sessions.

Kindly complete the requested information, and sign and date below your agreement to go forward with the terms of this contract. **PLEASE PRINT** as follows:

Your Name: _____

Date of Birth: _____

E-Mail address: _____

Telephone Number that you wish to be contacted at: _____

Residence address including Zip code: _____

Credit Card Information for Payment:

Name as it appears on card: _____

Type of Card: _____ (e.g., Visa, Amex, Debit) *

Credit Card #: _____

Card Expiration Date: _____

Security Code: _____

Zip code for card billing address: _____

Cancellations: We understand that situations arise unexpectedly resulting in a need to change or cancel an appointment. To be fair to us, we ask that you provide notice to our practice via e-mail message or telephone call at least 48 hours in advance of your need to cancel or switch your appointment. **

Please sign below indicating your agreement to these terms:

Signature: _____Date: _____

Please e-mail or scan over a completed and signed copy of this form to: DrMark1@bellsouth.net

*All credit/debit card charges are subject to a .038.5% processing fee
** A "no show" charge will be incurred if you do not contact our practice in advance to change or cancel your scheduled appointment

I have read and understand the information provided above and am aware that I may ask for additional information. I hereby consent to telehealth services as a part of my treatment. Please initial here: _____

Our practice welcomes you and will do everything we can to assist you with achieving your goals.

Sincerely,
Michelle, Office Manager for:

Mark D. Ackerman, Ph.D.
Licensed Psychologist