Mark D. Ackerman, Ph.D.
Licensed Psychologist
2751 Buford Highway
Suite #410
Atlanta, GA 30324
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Psychologist Telehealth Informed Consent

Thank you for considering my services for telehealth (e.g. remote) evaluation/treatment sessions. Fees for these services are based on time requested by you and can be either 25- or 50-minute sessions. You have the option 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 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 secure, HIPPA- compliant technology platforms. By signing this agreement below 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.
Kindly complete the requested information, and sign and date below your agreement to go forward with the terms of this contract.

Your Name: ____

Your E-Mail address: ____

Telephone Number that you wish to be contacted at: _________________________

Preferred times for telehealth sessions: ________________________________

Credit Card Information:

Name as it appears on card: _________________________________

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

Card #: ____________________________

Card Expiration Date: ________________

Security Code: _____________________

Zip code for card billing address: _____________

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 .037.5% processing fee

Please do not hesitate to contact our office should you have any questions.

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

Thank you!

Sincerely,

Michelle, Office Manager for:

Mark D. Ackerman, Ph.D.
Licensed Psychologist