Mark D. Ackerman, Ph.D.
Licensed Psychologist
2751 Buford Highway
Suite #410
Atlanta, GA 30324
Telephone: 770-396-2206
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Website: ClinicalForensicPsychSvs.com

Psychologist Telehealth Informed Consent-Evaluation

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. Telehealth sessions are convenient and reduce the need for travel to our office. At times, access to a computer screen may not be available or desired, thus telephone sessions are also an option at your request. You also 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 acknowledge that telehealth (e.g., remote) sessions may be subject to "hacking," phishing and/or other efforts to obtain your confidential information 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 does take every possible step to ensure your confidentiality by using a secure, HIPPA- compliant technology platform. By signing this informed consent, you accept the risks associated with telehealth sessions 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" for safety concerning yourself or someone else, 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: _____

Fees: The fee for the initial 50-minute telehealth evaluation/consultation session is $350. and includes discussion of the presenting concern, brief assessment as indicated, guidance and treatment planning as requested by examinee but does not include a written report.
Most initial telehealth evaluation sessions have an in-office follow-up for further diagnostic evaluation which may include computerized psychological testing to assist with diagnosis and treatment planning.

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 include an additional .038.5% processing fee
** A "no show" charge equaling the cost of one session will be incurred if you do not contact our practice in advance to notify us that you need 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 evaluation and/or treatment plan. 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