Judith Schulman-Miller LCSW
6 Office Park Circle Suite 304
Birmingham, Alabama 35223

Contents of all psychotherapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client. Additionally, I agree that neither Judith Schulman-Miller nor her records may be subpoenaed.

Noted exceptions are as follows:
_____

CONFIDENTIALITY AND ITS LIMITATIONS

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature _____ Date_____

Text and Email Communication Informed Consent

Information contained in email messages and text messages may be privileged and confidential. There is some risk that protected health information contained in such email and text may be disclosed to or intercepted by unauthorized third parties. Please be aware that email and text communications can be intercepted in transmission or misdirected. Your use of email or text to communicate protected information to me indicates that you acknowledge and accept the possible risk of such communication.

I will respond to your email or text query, but to do so via email or text, you must provide your consent, recognizing that email or text is not a secure form of communication. I will use the minimum amount of protected information to respond to your query. Pleased consider communicating any sensitive information by telephone, fax, or mail. If you do not wish to communicate by email or text please call me at 223 0513 or make an appointment for an office visit.

If you wish to conduct discussions regarding our therapy by email or text, please indicate your acceptance of the risk by signing below.

Client Signature _____ Congregation Signature_____

Date _____ Date _____

Telemental Health Informed Consent

_____, (name of client) hereby consents to participate in telemental health with Judith Schulman-Miller as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health: 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled. 2) I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required. 6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 205-223-0513 to discuss since we may have to re-schedule. 7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. Emergency Protocols I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a lifethreatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone: _____
_____ I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____ Signature of client/parent/legal guardian Date
_____ _____ Signature of therapist Date