Kristen Herzel, Ph.D.
Developmental Neuropsychology
PA Licensed Psychologist PS 009271-L
DE Licensed Psychologist B1-0011433
PA Certified School Psychologist 02039315
Licensed to Practice Interjurisdictional Telepsychology under PSYPACT
1489 Baltimore Pike, #208, Springfield, PA 19064
(610) 541-0710

EMAIL AGREEMENT

Between client or legally authorized representative and Kristen Herzel, Ph.D.

Because email is not a secure form of communication, Kristen Herzel, Ph.D., and Associates, cannot ensure the confidentiality of email messages. Please use discretion when sending information that is sensitive in nature. Please review the information below and return the signed form indicating your preferences regarding the use of email.

1. **Please do not use email for urgent or emergency problems.** Since you cannot tell for certain when your message will be read, there is no guarantee of an immediate response. In an emergency, please telephone, or, if necessary, call or go to your nearest hospital Emergency Department for service.
2. **Do not use email for sensitive medical or mental health information.** I understand that clients often wish to communicate with a psychologist by email. Although email systems are generally password protected, email is not a secure form of communication. Therefore, I cannot guarantee confidentiality of email. I will not initiate email contact with you related to clinical information, but will provide a brief response to such initiations from you, if you give written consent for this below. I may initiate email contact with you regarding appointment times if you consent to this below.
3. **Your email message and subsequent correspondence with me may be printed and a copy placed in your client file.** This correspondence is then part of your client record. In most cases, the email will then be deleted from my inbox to protect your privacy.
4. **If you are sending emails from your office computer, be aware that your employer has the right to read your email if he or she chooses.**
5. **Email is not a substitute for personal contact between client and psychologist.** If you think you need to be seen, please call and make an appointment.

Permission to use email may be revoked in writing by you, the client, or your legally authorized representatives, or by myself, at any time.

Please indicate, by circling Yes or No, whether or not you wish to communicate with me by email, for each of the below listed purposes, and sign below:

Yes No To schedule/change appointments
Yes No To initiate discussion about clinically relevant issues
Yes No To allow me to communicate with teachers or others working with your child (if appropriate consents have already been obtained for this type of correspondence)

I have read the above information and understand the limitations of security on information transmitted. I understand that my psychologist cannot engage in in-depth communication with me electronically about my specific condition if I live outside the state in which my psychologist is licensed.

Client Name (please print): _____

Signature of Client or legally authorized representative: _____

Relationship to client: _____ Email address: _____