WISE MIND
PRACTICE

I, _____, hereby consent to have my therapist, Morgan Kupsinel LISW IADC LIMHP of Wise Mind Practice LLC communicate with me, where appropriate via e-mailing regarding the following aspects of my treatment: short answers to my questions, non-emergency issues, appointments, billing, etc. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my therapist and me or between my therapist and other providers including other providers, physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my therapist and me or members of her office staff, or between my therapist and other providers including other providers, physicians, nurse practitioners or pharmacists regarding my therapy and treatment will be made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Signature _____ Date _____