PATIENT COMMUNICATION CONSENT FORM

I, _____, am:
(print name)

(Please check one)

_____ a) a patient of PHYSIOCARE

_____ b) the legal representative of a patient, _____
(print patient's name)

(please initial below)

_____ I agree to allow PHYSIOCARE to contact me in the following methods regarding my private health information, evaluation, and treatment. I authorize PHYSIOCARE to leave messages for me when I am unavailable. I understand that messages may contain confidential information.

METHOD	NUMBER/ADDRESS	MESSAGES (YES/NO)	
_____ Home Phone	(_____)_____	☐ YES	☐ NO
_____ Cell Phone	(_____)_____	☐ YES	☐ NO
_____ Work Phone	(_____)_____	☐ YES	☐ NO
_____ Alternate Phone	(_____)_____	☐ YES	☐ NO
_____ Text Messages	(_____)_____	☐ YES	☐ NO
_____ Email	_____	☐ YES	☐ NO

(please initial below)

_____ I authorize PHYSIOCARE staff to discuss my healthcare information (which may include history, diagnosis, labs, evaluation findings, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ PHONE: _____

ACKNOWLEDGEMENT & CONSENT *(Please initial by each statement below)*

_____ I may want to communicate with PHYSIOCARE and the office staff by email. I understand the risks of communicating by email, in particular the privacy risks explained in the "Communication Risks and Guidelines". I understand that PHYSIOCARE cannot guarantee the security and confidentiality of email or text communication. PHYSIOCARE is not responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

_____ I understand that I may also communicate with PHYSIOCARE by telephone or during a scheduled appointment, and that email is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

_____ I understand that either I or PHYSIOCARE may stop using email as a means of communication upon my written request.

_____ I understand that a text can only be used for appointment reminders. By agreeing to text communication, I understand I must give a cell phone number and have a text enabled cell phone plan.

_____ I understand that I may revoke this consent at any time by so advising PHYSIOCARE in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

_____ I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction.

By my signature below I acknowledge that I have read and understand PHYSIOCARE'S "Communication Risks and Guidelines" and information provided on this consent form. I understand the risk associated with the different methods of communication, especially email and texting, and consent to the conditions, restrictions and patient responsibilities outlined in the Guidelines as well as any other instruction that PHYSIOCARE may impose.

_____

(Patient Name Printed) *(Date)*

_____

(Patient/Legal Representative Signature) *(Relationship to Patient)*