**Consent for Electronic Delivery & Communication**

**Piece by Piece Autism Therapy (PbyP)** uses various communication platforms to ensure the timely and accurate delivery of information conveniently and efficiently.

**Methods of Communication:**

* Email
* Text Messages
* Phone Calls
* Adobe Sign (HIPAA-compliant signature platform) for contracts, consents, and treatment plans
* Assessments required for insurance/medical necessity (Vineland & Rethink)

**General Considerations:**

* **Email Risks:** I understand there are risks associated with using email to communicate personal health care information. These risks include, but are not limited to:
	+ Email can be forwarded, printed, or stored without my knowledge.
	+ Emails may be sent to the wrong recipient or intercepted.
	+ Copies of emails may remain even after deletion.
	+ Email service providers may archive or inspect emails.
	+ Email delivery is not guaranteed, and emails may spread viruses.
* Email is treated with the same confidentiality as medical records, but common email services like Gmail or Yahoo are not secure and may be intercepted.
* PbyP staff may use encrypted email, though not consistently.
* Text messages are for quick, non-PHI communication and are not HIPAA compliant.
* Adobe Sign ensures HIPAA compliance for document delivery.
* Documents are stored in a HIPAA-compliant PbyP GSuite account for 7 years.

**PbyP Staff Responsibilities:**

* Staff will attempt to request confirmation of received messages when a timely response is needed.
* Emails may be routed to relevant team members for efficiency.
* Responses are typically provided within **2 business days**. If not, contact the Clinical Director or Owner.
* Correspondence may be added to the beneficiary’s medical record.

**Parent/Guardian Responsibilities:**

* Do not use email/text for emergencies; call 911 or contact your Case Supervisor/Clinical Director/Owner.
* Keep emails concise; schedule appointments for sensitive or complex issues.
* Confirm receipt of emails within **24-48 hours** to avoid delays in services.

 **Consent for Electronic Communication:**

* I understand the risks of electronic communication and acknowledge that standard email/text is not HIPAA compliant.
* I may revoke this consent at any time, though prior communication remains valid.
* I release PbyP staff from liability related to non-secure communications.
* I agree to comply with the outlined responsibilities.

***Please Initial in each space below that you consent to***

\_\_\_\_\_\_\_\_ I consent to receive electronic delivery of communication via email

\_\_\_\_\_\_\_\_ I consent to receive text messages from PbyP staff as they pertain to immediate platforms of communication for my child’s ABA program

\_\_\_\_\_\_\_\_ I consent to use Adobe Sign as a HIPAA-compliant platform to sign any documents requiring my signature to authorize ABA services

\_\_\_\_\_\_\_\_ I consent to complete required assessments as dictated by my child’s insurance funder and/or at the request of PbyP staff to properly develop an ethically sound and appropriate treatment plan for my child’s ABA program

\_\_\_\_\_\_\_\_ I consent to and understand if I prefer to receive documents in paper form, I must communicate this to the Clinic. Changes to these preferences may take up to 10 business days

***If the beneficiary is a minor and/or has a legal guardian, please indicate the relationship:***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**PRINTED NAME DATE**

**SIGNATURE DATE**