

Consent for SMS (text) Communications

These communications may include, but are not limited to, appointment reminders, test results, billing notifications, and other healthcare-related information. A copy of our privacy policy is available upon request and online at <https://fulllifeprimarycare.com/privacy-policy>.

Please review the following terms and conditions:

1. **Purpose:** SMS messages are used to enhance your experience with our practice by providing timely and efficient communications. These messages may include non-sensitive medical information, appointment confirmations, and reminders.
2. **Message Frequency:** The number of messages you receive will vary depending on your interaction with our practice. Typically, you will receive text messages only when necessary.
3. **Cost:** Standard messaging and data rates from your mobile carrier may apply. You are responsible for any charges incurred by receiving SMS messages from our practice.
4. **Privacy and Confidentiality:** We take your privacy seriously. However, SMS communications are not encrypted, and there is a risk that messages could be read by someone other than you. Please be aware of this risk before providing consent. SMS opt-in or Phone Numbers for the purpose of SMS are not being shared for marketing purposes
5. **Opt-Out:** You may opt out of receiving SMS messages at any time by replying "STOP" to any message you receive from us. After opting out, you will no longer receive text messages from us, except in urgent situations.
6. **Your Responsibilities:** It is your responsibility to ensure that we have your correct mobile phone number. If your number changes, please inform us promptly.

By checking this box, you agree to receive SMS communication (text messages) from Full Life Primary Care, messaging data and rates may apply, messaging frequency may vary, reply STOP to opt-out at any time, text HELP to [\(903\)257-3929](tel:9032573929) for immediate assistance, please refer to our privacy policy at <https://fulllifeprimarycare.com/privacy-policy>.

Patient Name: _____ Phone Number: _____

Signature: _____ Date: _____