

Consent to Communicate with Coastal Neuropsychological Services

Our office offers our patients the opportunity to communicate through different means. This form provides information about these methods and will be used to document your consent for us to communicate with you through these methods.

Email Communications:

Coastal Neuropsychological Service offers the opportunity to communicate via email. This form provides information about the risks of email, guidelines for email communication, and how we will use email communication. Because there is no guarantee of privacy, emailing sensitive and confidential information should be limited. It's important to understand that while most email accounts have safeguards in place to protect your privacy, no email system is perfect, and breaches in security could allow unauthorized parties to access your personal and confidential information.

Email Risks:

Communication by email has a number of risks which include, but are not limited to, the following:

- Email can be circulated, forwarded, and stored in paper and electronic files.
- Backup copies of email may exist even after the sender or the recipient has deleted his/her copy.
- Email can be received by unintended recipients.
- Email senders can easily type in the wrong e-mail address.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.

How We Can Use Email:

- Email communication may include, but is not limited to, information about scheduling appointments, billing questions, routine patient questions and transmission of patient forms.
- Email correspondences may also include information about therapy or neuropsychological testing.
- Though our goal is to limit the transmission of private information, when requested by the patient we, may provide sensitive information via email, such as neuropsychological summaries and reports.
- Emails to or from you may be made a part of your record.
- Without your permission (or unless your account is delinquent), we will not disclose your contact information, including email(s), to others unless required by state or federal law.

Guidelines for Email Communication:

- Email messages should not be time-sensitive. While we try to respond to emails within 48 hours, in some instances, it may take longer. Urgent messages or needs should be relayed to an urgent care facility. Do not use email for any medical emergencies, call 911 or go to your nearest emergency room.
- Please understand we do not provide advice via email. We will ask that you schedule a phone consultation or wait for your next scheduled appointment to discuss anything other than scheduling or billing.
- If your email requires a response, and you have not heard back from us within three (3) working days, first check your email's spam folder, and then call our office to follow-up and determine if we received your email.
- Take precautions to protect the confidentiality of email, such as safeguarding your computer password and using screen savers.
- Please do not include information through email you wish to be kept private.
- Inform us of changes in your email address.

Phone, text and Voice Message Communication:

In order to maintain a reasonable flow of communication, it may be necessary for us to leave a message on an answering machine, voicemail, or with a third party. It's important that you understand more than one person in a home or office may receive this call, be left with a message, or have access to these voice messages. This information also applies to communication through video messaging services such as Skype, Zoom, and FaceTime as well as text messaging. The recording of any communication with Coastal Neuropsychological Services, including traditional and video phone calls, is strictly prohibited.

Agreement:

I want to communicate with Coastal Neuropsychological Services by email. I understand the inherent risks of communicating by email, including the privacy risks explained in this form. I understand that Coastal Neuropsychological Services cannot guarantee the security and confidentiality of email communication including, but not limited to, written messages, file attachments, and internet links. Coastal Neuropsychological Services will not be responsible for emails or messages that are not received or delivered, or for the disclosure of personal or confidential information. I authorize Coastal Neuropsychological Services to communicate through any of the email addresses provided on any of our patient forms or during our email communications.

I understand that I may also communicate with Coastal Neuropsychological Services 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 information.

I understand that either I or Coastal Neuropsychological Services may stop using e-mail as a means of communication upon my written request. I understand that I may revoke this consent at any time by so advising 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 authorize Coastal Neuropsychological Services communicate via traditional phone and video phone services and leave messages (with the person who answers the phone, on an answering machine, or through voicemail) at any of the phone numbers provided on any of our client forms or during our phone communications. I understand that Coastal Neuropsychological Services cannot guarantee the security and confidentiality of these voice messages. Coastal Neuropsychological Services will not be responsible for messages that are not received or delivered, or for the disclosure of personal or confidential information.

I have read and understand the terms of this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail, phone, and voice message communications to and from Coastal Neuropsychological Services.

Patient/Parent/Legal Guardian Signature: _____ **Date:** _____

*If POA, copy of proof required