**Prestige Psychiatric Professionals**
**6619 N Scottsdale Rd, Suite 4**
**Scottsdale, Arizona, US - 85250**

# Communication Consents (v1.04)

## COMMUNICATION CONSENTS

FULL NAME: *

DATE OF BIRTH: *

**CONSENT FOR VOICE MESSAGING, ELECTRONIC MAIL AND TEXT MESSAGING**

***TERMS AND CONDITIONS***

**Prestige Psychiatric Professionals**
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**Scottsdale, Arizona, US - 85250**

This consent gives Prestige Psychiatric Professionals, LLC, (Prestige Psych) the authorization to communicate with you by utilizing voice message(s) (voicemail), electronic mail (email) message(s) and or SMS text message(s). PLEASE REVIEW IT CAREFULLY.

Prestige Psychiatric Professionals, LLC, is asking for consent to communicate with you via voice messaging, electronic mail messaging and or SMS mobile messaging. Some personal information may be included in these message(s) and these communication methods may or may not be HIPAA compliant and or secure. Prestige Psychiatric Professionals, LLC, is not responsible nor liable for any and or all non-secured communication(s) and or any patient information which is obtained by a third-party through one of these communication methods. SMS opt-in and phone numbers for SMS will not be shared with third parties and or affiliates for marketing purposes.

Information obtained as part of the SMS consent process will not be shared with third parties.

Message and data rates may apply.

Messaging frequency may vary.

You can opt out at any time by texting "STOP."

For assistance, text "HELP" or visit our Privacy Policy & Terms of Service.

Typically, message(s) will be sent for the following reasons.
• Appointment confirmation and reminders
• Wellness check-ups
• Lab results
• Billing questions

Prestige Psychiatric Professionals, LLC, will utilize the telephone number, cellular number and or electronic mail (Email) address you provided to Prestige Psychiatric Professionals, LLC, which is stored in your patient profile, for communication.
If at any time you no longer wish to receive SMS communication messages from Prestige Psychiatric Professionals, LLC, you can Reply STOP to a SMS message from Prestige Psychiatric Professionals, LLC to unsubscribe or you can Reply HELP to a SMS message from Prestige Psychiatric Professionals, LLC for more info.

By checking any of the boxes below, and signing this document, you give permission for Prestige Psychiatric Professionals, LLC to send you a message(s) in the means you designate, furthermore, by signing, you release Prestige Psychiatric Professionals, LLC of any and all liability associated with and or caused by the usage of this Consent, including HIPAA (Health Insurance Portability and Accountability Act of 1996) liability. You may change your permission(s) at any time, please notify Prestige Psychiatric Professionals, LLC, if you desire, in the future to modify or cease your permission(s).

Email reminders and messaging? * ☐ Yes ☐ No

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Mobile texting reminders and messaging? * ☐ Yes ☐ No

Voice reminders and messaging? * ☐ Yes ☐ No

I do not want to receive any type of messaging ? * ☐ Yes ☐ No

## PERMISSION TO COMMUNICATE WITH FAMLY & FRIENDS

In an effort to serve you better, you have the option of providing us with a list of family and friends with whom we may discuss your health information. You are not required to provide a list of names; however, due to the nature of your treatment with our Practice, we will be unable to discuss appointment dates and times, medications, lab work, billing issues, and/or any aspect of your care unless we speak with you personally. This authorization does not allow us to release medical records. It only allows for communication via telephone, email, and/or in person with our office.

*This authorization may be revoked at any time.*

NAME: _____

RELATIONSHIP _____

TELEPHONE NUMBER: _____

NAME: _____

RELATIONSHIP _____

TELEPHONE NUMBER: _____

I chose to allow the aforementioned people to participate in my care and I am aware that they may receive information regarding my appointment dates and times, medications, lab work, billing issues and/or any aspects of my care unless indicated below. I understand this authorization may be revoked at any time. However, no medical records will be released to them without a HIPAA compliant release of information being signed. * ☐ Yes ☐ No

DO NOT disclose or discuss information about;

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I chose to not allow anyone to participate in my care and I am aware that only I will be able to receive information regarding appointment dates and times, medications, labs work, billing issues and/or any aspects of my care unless this is a life-threatening emergency.

☐ Yes ☐ No

*Your signature below acknowledges your right to receive a copy of this form, upon request.*

Your signature below acknowledges you have read the following sections of this form.

• CONSENT FOR VOICE MESSAGING, ELECTRONIC MAIL AND TEXT MESSAGING

• PERMISSION TO COMMUNICATE WITH FAMILY & FRIENDS

Furthermore, my signature below demonstrates I have read and understand the information provided above regarding consent for voice messaging, electronic mail and text messaging and permission to communicate with family. I have discussed it with my mental health provider or designated assistant, and all my questions have been satisfactorily answered.

Terms are subject to change without prior notification.

DATE: *

**PATIENT SIGNATURE:** *