Consent to Communications:

With regard to any services rendered to me, care or case management activities, and all related administrative, operational, scheduling, clinical, or financial matters connected to my receipt of services, I expressly agree and consent that the physician practice, its physicians, providers, employees, and all affiliated or related entities, partners, contractors, service providers, and vendors involved in the provision, coordination, administration of services, billing, financial, or collection services (collectively, the "Practice Parties") may contact me via e-mail, text message, and calls, by any method, including automated means (e.g., an automatic telephone dialing system or similar device) or prerecorded and/or artificial voice messages to any telephonic number that I have provided to the Practice Parties or at a number forwarded or transferred from that number, including mobile telephone numbers. Messages may include my name, the name of the physician practice, provider, and/or any relevant billing agents.

I understand message frequency will vary based on the services I receive from the Practice Parties and message and data rates may apply. To revoke permission to receive text messages or to request further assistance regarding text messages, I must do so using the opt-out and assistance methods communicated by the Practice Parties.

I understand that communications with Practice Parties electronically, such as by e-mail or text messaging, may contain my health information. These electronic communications occur over the internet or through my mobile carrier, and there is a risk that my health information could be intercepted or viewed by third parties, including others who access my device. Password-protecting mobile device(s) or user accounts and enabling encryption on my devices, if available, is recommended.

_____

Patient Name

_____

Signature of Patient or Authorized Representative Date

Relationship to Patient: _____