



PATIENT COMMUNICATION CONSENT FORM

I, _____, am:
(print name)

(Please check one)

_____ a) a patient of OUTPATIENT PHYSICAL THERAPY

_____ b) the legal representative of a patient, _____
(print patient's name)

(please initial below)

_____ I agree to allow OUTPATIENT PHYSICAL THERAPY to contact me in the following methods regarding my private health information, evaluation, and treatment. I authorize OUTPATIENT PHYSICAL THERAPY to leave messages for me when I am unavailable. I understand that messages may contain confidential information.

METHOD	NUMBER/ADDRESS	MESSAGES (YES/NO)	
_____ Home Phone	(_____) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____ Cell Phone	(_____) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____ Work Phone	(_____) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____ Alternate Phone	(_____) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____ Text Messages	(_____) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____ Email	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

(please initial below)

_____ I authorize OUTPATIENT PHYSICAL THERAPY staff to discuss my healthcare information (which may include history, diagnosis, labs, evaluation findings, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME

RELATIONSHIP TO PATIENT

CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ **PHONE:** _____

ACKNOWLEDGEMENT & CONSENT *(Please initial by each statement below)*

_____ I may want to communicate with OUTPATIENT PHYSICAL THERAPY and the office staff by email. I understand the risks of communicating by email, in particular the privacy risks explained in the "Communication Risks and Guidelines". I understand that OUTPATIENT PHYSICAL THERAPY cannot guarantee the security and confidentiality of email or text communication. OUTPATIENT PHYSICAL THERAPY is not responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

_____ I understand that I may also communicate with OUTPATIENT PHYSICAL THERAPY 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 medical information.

_____ I understand that either I or OUTPATIENT PHYSICAL THERAPY may stop using email as a means of communication upon my written request.

_____ I understand that a text can only be used for appointment reminders. By agreeing to text communication, I understand I must give a cell phone number and have a text enabled cell phone plan.

_____ I understand that I may revoke this consent at any time by so advising OUTPATIENT PHYSICAL THERAPY 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 have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction.

By my signature below I acknowledge that I have read and understand OUTPATIENT PHYSICAL THERAPY'S "Communication Risks and Guidelines" and information provided on this consent form. I understand the risk associated with the different methods of communication, especially email and texting, and consent to the conditions, restrictions and patient responsibilities outlined in the Guidelines as well as any other instruction that OUTPATIENT PHYSICAL THERAPY may impose.

(Patient Name Printed)

(Date)

(Patient/Legal Representative Signature)

(Relationship to Patient)