Breakthrough
Mental Healthcare LLC

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## PATIENT COMMUNICATION FORM

Date: Name: DOB: Age:

**Part 'A':** Do you authorize any person(s) to send communications to, receive communications from, or otherwise communicate with Breakthrough Mental Healthcare LLC ("Provider") on your (or in the case of a minor child, the minor child's) behalf regarding all healthcare matters? [ ] Yes [ ] No

**If you checked "No" in Part 'A', please skip Part 'B' and complete Part 'C'**

**Part 'B':** The following person(s) are hereby authorized to send communications to, receive communications from, or otherwise communicate with Provider on my (or in the case of a minor child, the minor child's) behalf:

Name: Relationship:

Name: Relationship:

Name: Relationship:

**Part 'C':** Patient Name: DOB:

Patient Signature: Date:

**If Patient is a Minor Child, please complete and sign below.**

Print Name of Minor Child Patient: _____

Minor Child's Date of Birth: ____/____/_____

Print Name of Parent/Guardian/Managing Conservator: _____

Signature: _____ Date: ____/____/_____
Parent/Guardian/Managing Conservator

## PATIENT COMMUNICATION CONSENT

I hereby authorize Provider to contact me in the following methods regarding my (or in the case of a minor child, the minor child's) protected health information and general information regarding medical diagnosis and treatment.

Method Number/Address Messages (Y/N)

[ ] Home Phone [ ] Yes [ ] No [ ] Work Phone [ ] Yes [ ] No [ ] Cell Phone [ ] Yes [ ] No [ ]

Voice Phone [ ] Yes [ ] No

[ ] Text Messages [ ] Yes [ ] No (Texting requires that you give us your cell number and for you to have a text enabled cell phone)
[ ] Email [ ] Yes [ ] No [ ] Physical Mail [ ] Yes [ ] No

## PATIENT EMAIL AND TEXT MESSAGING INFORMED CONSENT

### 1. Risk of Using Email and Text Messaging

The transmission of client/patient information by email and/or texting has a number of risks that clients/patients should consider prior to the use of email and or texting. These risks include, but are not limited to, the following:

(a) Email and texts can be circulated forwarded, stored electronically and on paper, and broadcast to unintended recipients;

(b) Email and text senders can easily mis-addressed an email or text and send information to an unintended recipient;

(c) Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy;

(d) Employees and online services have a right to inspect emails sent through their company systems; (e)

Emails and text can be intercepted, altered forwarded, or used without authorization or detection; (f)

Email and texts can be used as evidence in court; and

(g) Emails and texts may not be secure and therefore it is possible that the confidentiality of such communication may be breached by a third party.

### 2. Conditions for the Use of Emails and Text Messaging

Provider cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Provider is not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Clients/Parents/Legal Guardians/ must acknowledge and consent to the following conditions:

(a) Email and texting are not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time;

(b) Email and texts should be concise;

(c) The Client/Parent/Legal Guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations;

(d) All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well;

(e) Provider will not forward Client's/Parent's/Legal Guardian's identifiable emails and/or texts without written consent from Client/Parent/Legal Guardian, except as authorized by law;

(f) Clients/Parents/Legal Guardians should not use email or texts for communication of sensitive medical information;

(g) Provider is not liable for breaches of confidentiality caused by the client or any third party; and

(h) It is the Client's/Parent's/Legal Guardian's responsibility to follow up and/or schedule an appointment if warranted.

**PATIENT ACKNOWLEDGEMENT AND AGREEMENT**

I acknowledge that I have read and fully understand this consent form. I understand the risk associated with the communication of email and/or text messaging between my Provider and myself, and I consent to the conditions and instructions outlined as well as any other instructions that my Provider may impose to communicate with me by email or text.

Patient Name (Print): Date:

Patient Signature:

**If Patient is a Minor Child, please complete and sign below.**

Print Name of Minor Child Patient: _____

Minor Child's Date of Birth: ____/____/_____

Print Name of Parent/Guardian/Managing Conservator: _____

Signature: _____ Date: ____/____/_____
Parent/Guardian/Managing Conservator