



Patient's Notification Policy and Consent

Patient's Name: _____ **DOB:** _____

In Order to ensure that patients receive time- sensitive information and other informational healthcare messages, we, as the provider of rehabilitation therapy ("Provider", "we, "or "our") send notifications to patients that opt-in to receive such notifications. If you (Patient is referred to herein as ("you, "I," me,"my,"yourself,"and "your") choose to sign this consent and opt-in to receive such notifications from Provider, Provider will not impose a separate charge for these notifications; however, depending on the terms and conditions of your wireless carrier contract and/or plan, fees and/or restrictions may be imposed upon you for receiving notifications from Provider. Please contact your wireless carrier about such fees and/or restrictions prior to providing your consent herein to such notifications from Provider.

It is important to note that certain communications, including, without limitation email and text message, which may contain your protected health information ("PHI"), are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), we are required by law to maintain the privacy and security of your PHI. In addition, pursuant to the HIPAA Privacy Rule and Provider's Notice of Privacy Practices, we will not use and/or disclose your PHI without your explicit written authorization, except as permitted by law for the purposes of payment, treatment and health care operations, Furthermore, when we are authorized and/or permitted to use and/or disclose of your PHI, If you choose to have Provider disclose your PHI to an individual or entity other than yourself, you must properly complete Provider's HIPAA Authorization Form, which is available at the front desk upon request.

You have the right to revoke this consent by providing written notice of revocation to the Privacy Officer at Provider. The revocation will become effective on the day the Privacy Officer receives the revocation of the consent, and any prior notification from Provider will not be subject to such revocation of the consent.

I, the undersigned, hereby consent to receive notifications from Provider, which notifications may include my PHI, by the following methods of communication that I indicated below, with a full understanding of the risks involved with such notifications from Provider, and I agree to assume all responsibility for informing Provider in writing of any changes to any of the methods of communications that I indicated below and for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable, and I further agree that Provider shall not be

held liable for any unauthorized disclosures of my PHI to a third party through any of the methods of communication I authorized below or for any fees and/or restrictions that may be imposed upon me for receiving notifications from Provider:

Mobile Device*: (_____)_____

Test Message*: (_____)_____

Wireless Carrier: _____

Mobile Device*: (_____)_____

Test Message*: (_____)_____

E-Mail: _____

Opt-out of receiving text message and email communications from Provider

*wireless carrier's standard message rates, data rates, and/or restrictions may apply and by consenting to receive notifications from Provider you agree to be solely responsible for all fees that you incur from receiving notifications from Provider.

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

Patient/Legal Guardian Name: _____