Carolina
COUNSELING
CONSULTANTS
PURPOSE DRIVEN COUNSELING SERVICES

WWW.CAROLINACOUNSELINGCONSULTANTS.COM

Electronic Communications Consent Form

Risks of Communication by Email, Text Message, and Other Non-Secure Means:
It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Receiving appointment reminders and payment receipts for services by email or text message fall into this category as well. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept these messages. Some of the potential risks you might encounter using these methods of communication include: • People in your home or other environments who access your phone, computer, or other devices that you use might read your email or text messages. • Loss of cellular phone, computer, or other devices. • Email accounts can be hacked. • Text messages and emails are stored on servers. • Mis-delivery of email to an incorrectly typed address. • Third parties on the Internet such as server administrators who monitor Internet traffic might intercept your communication. Please limit the use of electronic communications to issues related to scheduling. If you choose to email me, please be aware my email responses will be brief, and I may call you to discuss the matter. I may not respond to text messages or emails that are not related to scheduling or if they are sent outside of business hours.

Please circle the unsecured methods in which you approve/disapprove to be contacted:

Contact by telephone: NO YES Contact by text: NO YES

Leave voice message: NO YES Contact by email: NO YES

Receive receipts by: Email Text Printed Receipt No Receipt Needed

Receive appointment reminders via: Email Text Voice Message

My signature below indicates I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Name of Client _____

Printed Name of Parent/Guardian or Legal Representative (if applicable)

_____

Signature of Client or Parent/Guardian or Legal Representative (if applicable)

_____ **Date** _____