

3610 Avenue B, San Antonio, TX 78209
P: 210-313780 F: 210-585-2899

PATIENT COMMUNICATION CONSENT

People-Centered Health offers two communication channels for patients. This form describes both channels and allows you to provide consent for either, both, or neither. Consent is not required to receive medical care from People-Centered Health.

CHANNEL 1: Direct Clinical Communication with My Provider

I consent to receive direct text messages and emails from my provider regarding my medical care, including health advice, medical recommendations, treatment plans, lab and imaging results, prescription information, and care coordination. These messages come from my provider's direct contact number or email.

I **acknowledge** that text and email are not HIPAA-secure and may include protected health information. I accept this risk in exchange for the convenience of direct communication.

<input type="checkbox"/> I CONSENT to direct clinical communication via text and email.	Initials: _____
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Opt-out: notify the practice in writing.

CHANNEL 2: Automated SMS Notifications

I consent to receive automated text messages from People-Centered Health's practice management system, sent from a dedicated number separate from my provider's direct contact. These automated messages include lab order scheduling notifications, appointment reminders, care plan check-ins, annual wellness reminders, and similar transactional notifications. Automated messages will not include sensitive clinical details.

Message frequency varies based on care needs. Standard message and data rates may apply. Opting out of automated notifications will **not** affect direct provider communication (Channel 1).

<input type="checkbox"/> I CONSENT to automated SMS notifications.	Initials: _____
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Opt-out: reply STOP to any automated message, or notify the practice in writing. Reply HELP to any message for assistance, or call (210) 314-3780.

Privacy. Mobile phone numbers and SMS opt-in information are used solely for communication between People-Centered Health and the patient. NO MOBILE INFORMATION WILL BE SHARED WITH THIRD PARTIES OR AFFILIATES FOR MARKETING OR PROMOTIONAL PURPOSES. See our *Website Privacy Policy* at peoplecentered.health for more information.

PATIENT INFORMATION

Patient Name (Printed)

Date of Birth

Mobile Phone

Email

By signing below, I confirm that I have read this form, understand the two communication channels, and have indicated my consent (or non-consent) for each by my initials above.

Patient Signature

Date