Consent for Communication

Purpose of This Consent

This consent authorizes Pediatric Neuropsychology Associates PLLC to communicate with the patient and/or parent/legal representative regarding appointments, treatment-related matters, billing, and other practice-related communication, in accordance with HIPAA and applicable Florida privacy laws.

This consent does not replace in-person clinical services and does not authorize communication for emergency or crisis intervention.

Email and text messaging may offer convenience, but they are not fully secure. Standard unencrypted communication (such as standard email or SMS text) carries some risk that messages could be potentially accessed by unauthorized individuals.

We are providing this information so you make an informed decision about your communication preferences. You may choose or decline any communication methods based on your comfort level.

Patient Information

Patient Name: _____

Date of Birth: _____

Parent/Legal Representative Name: _____

Relationship to Child: _____

Methods of Communication

The secure message portal is the preferred method for communication when available. I consent to receiving communications from Pediatric Neuropsychology Associates PLLC through the following methods (check all that apply and initial to confirm):

Communication Method	Acceptable	Initial
Unencrypted Email (e.g., Gmail, Yahoo, etc.)	☐ Yes ☐ No	
Phone calls (including voicemail messages)	☐ Yes ☐ No	
Text Messages (SMS)	☐ Yes ☐ No	
Secure Message Portal (PracticeQ)	☐ Yes ☐ No	

Preferred Email Address: _____

Preferred Phone Number (calls/texts): _____

Description of Communication

Communication Type	Acceptable	Initial
Appointment reminders, confirmations, or cancellations	☐ Yes ☐ No	
Scheduling or billing inquiries	☐ Yes ☐ No	
Clinical information or treatment-related messages	☐ Yes ☐ No	
Other practice-related notifications	☐ Yes ☐ No	

Risks and Confidentiality

I understand that:

- Unencrypted communications are not guaranteed to be secure or confidential
- Messages may be intercepted, misdirected, or accessed by unauthorized persons
- Emails or texts may be accessed from lost/stolen devices
- Messages may be stored by third-party servers (email providers, carriers)
- Some communications (including email and text messages) may become part of the medical record when clinically relevant
- Standard message and data rates may apply
- The practice is not responsible for technical failures or delivery delays
- I must notify the practice if my contact information changes
- These communication methods should not be used for urgent or emergency matters; in those cases, I should call 911 or seek emergency care
- Confidentiality of clinical services, records, and disclosures is governed separately by the Notice of Privacy Practices and applicable law

Opt-Out and Changes

I understand that I may change or revoke my communication preferences at any time by notifying the practice in writing or through the patient portal. My care will not be affected by my communication choices.

Social Media and Informal Electronic Communication

To protect privacy, confidentiality, and professional boundaries, Pediatric Neuropsychology Associates PLLC does not communicate with patients or families through social media platforms, personal messaging applications, or public comment features.

I understand that social media direct messages, comments, or personal accounts should not be used to contact the practice regarding appointments, clinical questions, concerns, or urgent matters. Such communications may not be secure, may not be monitored, and may not receive a response.

I agree to use only the communication methods authorized in this consent form (such as phone, email, text, or the secure message portal, when available) for all practice-related communication.

Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

Parent or Legal Representative Consent and Acknowledgment (for Minors or Individuals Lacking Legal Capacity)

I acknowledge that I have read and understand the Consent for Communication of Pediatric Neuropsychological Associates PLLC and the risks associated with unencrypted communication. I authorize Pediatric Neuropsychology Associates PLLC to communicate with me using the selected methods above. By signing below, I confirm that I am the parent or legal representative of the patient named below and have the authority to consent on the patient's behalf.

Printed Name of Patient: _____

Printed Name of Parent/Legal Representative: _____

Signature of Parent/Legal Representative: _____

Relationship to Patient: _____

Date: _____

A copy of this signed consent will be retained in the patient's health record.

For Office Use Only

Date Received: _____

Received By: _____

Staff Role: _____

Filing Method: ☐ Paper File ☐ Digital File ☐ Both

Notes: _____