Agreement to Receive Electronic Communication and Telehealth/Telemedicine Services

Patient Name: _____ Date of Birth: _____

Please Initial: I **DO** Agree: or I **DO NOT** Agree:

That CMPS may communicate with me electronically at the previously listed email address and/or phone number.
I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the business any updates to my email address and/or mobile phone number.

Most Preferred Method of Communication: ☐ Email ☐ Text Message ☐ Both

***Please remember that text and email reminders are a courtesy and not a guarantee. Patients or their parent/guardian are fully responsible for keeping track of and remembering scheduled appointments.**

I hereby consent to engaging in telehealth/telemedicine services with Coastal Medical and Psychiatric Service, Inc, as part of my mental health resources, psychotherapy, and medication management. I understand that telehealth/telemedicine Includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth/telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Virginia. **INITIAL:** _____

Acknowledgment of Welcome Letter & Privacy Notice Packet

I hereby acknowledge that I have received a copy of the Privacy Practices of CMPS, Inc.

Patients Name: _____

Date: _____

Signature of Patient or Parent/Guardian: _____

If you are signing as the personal representative of the patient:

Personal Representatives Name: _____