

Patient SMS Text Messaging Consent Form

South County Endocrinology and Obesity Medicine

To better serve our patients, **we offer** text messaging services for convenient communication. By signing this form, you authorize us and our authorized representatives to send text messages to your mobile phone number.

Types of Messages You May Receive

These communications may include, but are not limited to:

- Appointment reminders and scheduling updates
- Billing notifications, payment reminders, or statements.
- General practice announcements, office closures, or health alerts.
- Direct 2-way messaging with our office staff regarding your care.

Patient Acknowledgment & Important Privacy Information

By signing below, I understand and agree to the following terms:

- **Privacy Risks:** Text messaging is generally not a secure or encrypted form of communication. There is some risk that health information contained in a text message could be intercepted or viewed by unauthorized third parties.
- **Voluntary Participation:** Opting into text messaging is entirely voluntary. Your consent is not a condition of receiving medical treatment or services at our practice.
- **Carrier Charges:** Standard message and data rates may apply depending on your mobile carrier provider. **[Practice Name]** is not responsible for any text messaging charges you may incur.
- **Frequency:** Message frequency varies based on your scheduling and care needs.
- **Revocation (Opting Out):** You can opt out of receiving text messages at any time. To stop receiving messages, you can simply reply with **"STOP"** to any text message you receive from us, or contact our office directly to update your preferences.

Patient Consent & Authorization- Please check **ONE** of the boxes below:

YES, I CONSENT. I authorize **South County endo and Obesity med** to send automated and manual text messages to the mobile number listed below.

NO, I DECLINE. I do not consent to receive text messages from **South county endo and obesity med**

Patient Printed Name: _____

Patient Date of Birth: _____

Signature: _____ Date: _____

