Communication Preference Form

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your care. As such, please indicate your communication preferences below. Mindful Wellness, LLC and its service providers is/are not considered a "Covered Entity" under HIPAA and therefore HIPAA requirements do not apply.

For information pertaining to me such as documentation of services, appointment reminders, etc. I hereby grant permission to **Mindful Wellness, LLC**, including it's owners, directors, managers, officers, providers, employees, contractors, and agents (collectively referred to as "Company") to communicate with me as follows:

Unencrypted Email

I grant Company permission to provide me with written communication via unencrypted email service. I understand that such communication may not be secure under HIPAA and may be viewed by an unintended third party. I fully waive my HIPAA rights with respect to such communication and accept this risk and authorize such communication.

Text Messages

I grant Company permission to provide me with written communication including appointment reminders via text message. I understand that text messages are an unencrypted form of communication and may be viewed by an unintended third party. I fully waive my HIPAA rights with respect to such communication and accept this risk and authorize such communication.

Telephone Communications

I authorize Company to communicate serivices and other information with/to me via telephone through the numbers provided by my to Company from time to time. I understand that Company telephone may not be secure under HIPAA and may be viewed and/or accessed by an unintended third party. I fully waive my HIPAA rights with respect to such communication and accept this risk and authorize such communication.

Voicemail and Messages

I grant Company permission to leave relevant services information on my answering machine or voicemail. I understand that such messages may not be secure under HIPAA and may be viewed and/or accessed by an unintended third party. I fully waive my HIPAA rights with respect to such communication and accept this risk and authorize such communication.

Use of Unencrypted Services By Me

I understand that regardless of what I may have checked in this form or in other documents, that if I choose to send emails, texts to Company, or use other online and/or social media platforms to communicate with Company, through a non HIPAA secure provider, or communicate with Company through any other non HIPAA secure means, then I hereby waive any and all potential HIPAA claims or complaints that may arise out of or be related to such communications including but not limited to subsequent responses and communication by Company that may be sent through unsecure means. Initials _____

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

Patient Name: _____ Date of Birth: _____ Date_____

Signature of Patient or Legal Representative_____Relationship to Patient_____