B.O.B.
Bio-Optimized Body
WELLNESS • BODY • MIND

Patient Consent for Email and Text Communication

Patient Name:_____**Date of Birth:**_____

Cell #:_____ **Email Address:**_____

Bio-Optimized Body offers the option to communicate with patients via email and text for convenience. However, email and text communication carries inherent privacy risks, and it is important that you understand these risks before granting consent.

1. Risks of Email and Text Communication
By consenting to receive email and text communications from our office, you acknowledge and accept the following risks:

- Emails and texts may not be secure and could be intercepted by unauthorized parties.
- There is a risk of emails and texts being misdirected or sent to the wrong recipient.
- Email and text messages may be stored on various servers, increasing exposure to potential breaches.
- Email and texts should not be used for urgent or emergency medical issues.

2. Permitted Uses of Email and Text Communication
By signing this form, you authorize our office to send emails and texts containing:

☐ Appointment reminders and scheduling information
☐ Treatment plans and follow-up instructions
☐ Prescription and medication information
☐ Billing statements and payment inquiries
☐ General health information related to your care
☐ Other (please specify):_____

Note: Our office will make reasonable efforts to protect your privacy but cannot guarantee complete confidentiality of email communications.

3. Patient Responsibilities

- You must provide an accurate and secure email address.
- You should notify our office of any changes to your email address or phone number.
- You understand that email or text messages should not be used for urgent medical needs.
- You acknowledge that you can withdraw this consent at any time in writing.

4. Patient Acknowledgment & Authorization

I have read and understand the risks associated with email and text communication. I agree to allow Bio-Optimized Body to communicate with me via email and text as outlined above. I understand that I may revoke this consent at any time by providing written notice.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**

If patient is a minor or unable to consent:

Parent/Guardian Name:_____

Relationship to Patient: _____

Parent/Guardian Signature: _____ Date:_____

For Office Use Only:

☐ Consent received and documented in patient record

☐ Email address verified