**L. Shannon Stephens, M.S., LPC, NCC**

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**EMAIL AND TEXT MESSAGING CONSENT FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient printed name) (Therapist name)

to send automated appointment reminder email and/or text messages to me. I understand my Therapist is not responsible for any breach of privacy, confidentiality, or security of the emails/texts once they are received on my electronic devices. I understand the reminder system is automated and does accept reply emails/texts and is used for the sole purpose of appointment reminders. I agree to call the Clinicians Office at 706-364-0252 within regular business hours to cancel/reschedule appointments. I understand I may be charged a late cancellation/no show fee if I do not honor the 24-hour cancellation notice policy. In the case of an emergency, I agree to notify the office as soon as possible.

**Contact by text messages:**

* I **DO** wish to have this contact at the following phone number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I **DO NOT** wish to have this contact.

**Contact by email:**

* I **DO** wish to have this contact at the following email address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I **DO NOT** wish to have this contact.

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(Patient/Custodial Parent/Legal Guardian) (Date of Signature)