



Body in Balance Physical Therapy, Inc.

Patient Name _____

Agreement for the Use of Texting and Email Methods of Communication

I have been notified that email and texting are not secure methods of communication. I agree to the use of email and/or texting with Body in Balance Physical Therapy, Inc. for scheduling appointments and other physical therapy needs. Staff may also communicate with my family and/or household members using the method checked below:

Email _____

Texting _____

Email Address _____

Cell Phone _____

I understand that it is my responsibility to notify Body in Balance Physical Therapy, Inc. when:

- The cell phone numbers or email addresses listed above change
- I not longer want to use these methods for communication with Body in Balance Physical Therapy, Inc.

I understand that Body in Balance Physical Therapy, Inc. will not charge me for the text or email messages and that I am responsible for any charges that I may incur under my current service plan.

Patient's signature _____ Date _____

Or Authorized Representative's Printed Name _____

Address _____ Phone _____

Authority under ME/NH law (e.g., guardian, health care power of atty.)

Authorized Rep's Signature _____ Date _____

If signed by Authorized Representative, the person's authority to act as such has been verified by the clinician.

Clinician's Signature _____ Date _____