Silver Psychiatric Services, PC
Randie Schacter, DO
212 W. Matthews Street Suite 106
Matthews, NC 28105
Tel 704-847-0424 Fax 704-847-0454

CONSENT TO USE ELECTRONIC COMMUNICATIONS

Dr. Schacter has offered to communicate using the following means of electronic communication ("the Services") [check all that apply]:

- ☐ Email
- ☐ Website/Portal
- ☐ Appointment reminders by texts **(NOT FOR ANY OTHER PURPOSE)**
- ☐ Videoconferencing (including Skype®, FaceTime®)
- ☐ Other (specify): _____

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with Dr. Schacter and her staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that Dr. Schacter may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with Dr. Schacter or her staff using the Services may not be encrypted. Despite this, I agree to communicate with Dr. Schacter and her staff using these Services with a full understanding of the risk. I acknowledge that either I or Dr. Schacter may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

I also acknowledge that <u>outside of our appointment times</u> (where information can be shared live over a secure portal), <u>all electronic communication is limited to administrative, non-clinical, non-emergent or non-urgent issues</u> and that it is my responsibility to follow up with Dr. Schacter's office by phone or in session for clinical issues regarding symptoms and medications.

I further understand that I may request a copy of this signed authorization.

Patient name: _____

Patient address: _____

Patient home phone: _____ Patient mobile phone: _____

Patient email (if applicable): _____

Signature of Patient/Authorized Person: _____Date: _____

Name of Authorized Person: _____ Relationship: _____