POSITIVE PERSPECTIVES, INC.

AUTHORIZATION FOR CONTACT AND MAILINGS

Client Name:___________________________________ Social Security Number:____________________

It is sometimes necessary or helpful for Positive Perspectives, Inc. to contact you between sessions, either by phone or through the mail. This form allows you to specify how, where, and in what manner you would like to be contacted. If you do not wish to place any restrictions on how to contact you, please complete only the top part of the page. Thanks!

I grant Positive Perspectives, Inc. permission to reach me at the following numbers; messages may be left on my personal cellphone:

Cell Phone_____________________________ Initials________

Home Phone____________________________ Initials _______

Work_________________________________ Initials________

Other________________________________ Initials________

I agree to receive therapy over the Doxy.me HIPAA-Secure video platform Initials________

I understand that my counselor is not likely to have a telemedicine certification but is providing this service to me during a time of crisis in order to meet my therapeutic needs. Initials________

I agree to receive text messages on my personal cellphone (which is not HIPAA-Secure) Initials________

I agree to receive non-encrypted emails from PPInc Staff or Counselors; these are not HIPAA-Secure. Initials________

I agree to receive mailings at my home address. Initials_______

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Signature **Date**

ONLY COMPLETE THIS PORTION IF YOU ARE PLACING RESTRICTIONS ON CONTACT:

If you wish to specify any limitations on our ability to contact you, please explain them here:

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Do not leave messages on my personal cellphone Initials ______________

Mail may only be sent to the following specified location:

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You *may not* send me any mailings other than billing notices Initials ______________

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Signature Date Rev 4/20 CBL