GI Associates & Endoscopy Center
powered by GI Alliance

Methods of Communication

Patient Name: _____ Birth Date: _____

TEXTS and EMAILS

By signing below:

1. I consent to receive text messages and/or calls from Practice (or its vendors), including calls and messages using automated dialing technology, at the cell phone number(s) on file with Practice; and

2. I consent to receive emails from Practice (or its vendors) at the email address(es) on file with Practice.

Calls, text and/or emails from Practice may include information relating to my healthcare services, financial obligations, appointment reminders, referrals, prescription information, or promotional or other marketing offers and services from Practice. I understand that these messages are unencrypted and there is risk that information included in the messages may be intercepted by unintended third parties and/or stored by our service providers and system operators. My consent is not a condition to receive services and message and data rates may apply. To stop receiving text messages, I may opt-out by texting STOP. To stop receiving email messages, I may opt-out by unsubscribing.

_____ _____

Signature Date

_____

Printed Name of Patient

If signed by patient's representative, description of authority (such as parent/guardian):

_____