TicTalkToes
SPEECH AND OCCUPATIONAL THERAPY

Preferred Communication Form

Client Name: _____ *D.O.B:* _____

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

I wish to be contacted in the following manner (please check all that apply):

Cellphone

- ☑ Ok to leave voicemail message with detailed information
- ☑ Leave voicemail message with call back number only
- ☑ Do not call or leave voicemail messages on my cell phone

_____*(initials) I understand that with the following option, written communication may be viewed by an unintended third party and I fully accept this risk.*

- ☑ Ok to leave text messages with detailed information
- ☑ Leave text messages with call back number only
- ☑ Do not leave text messages on my cell phone

Work/Home Phone

- ☑ Ok to leave message with detailed information
- ☑ Leave message with call back number only
- ☑ Do not call or leave messages on work/home phone

Email (please note: this will be sent through a non-encrypted email)

- ☑ Ok to leave email with detailed information
- ☑ Okay to leave email but do not leave any detailed information
- ☑ Do not email me

Written Communication

_____*(initials) I understand that with the following option, written communication may get lost or viewed by an unintended third party and I fully accept this risk.*

- ☑ Ok to mail my home address with marked email address
- ☑ Ok to mail me via USPS in an unmarked envelope
- ☑ Do not mail me

(408) 634-4912
1769 Park Ave, STE 210
San Jose, CA 95126
tictalktoestherapy@gmail.com

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It is okay to discuss the personal health information and appointment information with the following people (please list names and contact information):

☑ Spouse/Partner: _____

_____

☑ Primary Care Provider/Specialist _____

_____

☑ Therapist/Mental Health Counselor _____

_____

☑ Other _____

_____

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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