Advanced Clinicians Specialty Services

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Communication Policy

The following document contains information about the use of electronic and non-electronic communication methods at Advanced Clinicians Specialty Services. Many of these methods are common modes of communication, however, as they can pose a potential risk to your privacy, we aim to maintain a standard consistent with the law and ethical standards of our professions). Therefore, this policy has been prepared to assure the security and confidentiality of your treatment in compliance with relevant ethical and legal standards. Please read it carefully and note any questions that you may have. When you sign this document, it will represent an agreement between you and Advanced Clinicians Specialty Services.

Consent to Contact
In accordance with the HIPPA Privacy Rule, we will not contact the patient or leave a voicemail or message with someone without the patient's consent. We will also not leave a message at a place of employment. However, in certain instances, it can be important for patients to be informed of logistical concerns relative to their treatment (e.g., appointment reminders). Accordingly, please choose one of the below statements to indicate your preference for contact:

_____ Initial: You MAY NOT contact me by phone and/or leave me a message for appointment reminders or to notify me of a doctor/therapist cancellation. I understand that I am responsible for keeping my appointments and that a missed appointment fee will be charged for appointments canceled less than 24 hours advance. By choosing this option, I assume full responsibility for maintaining awareness and attendance of my appointments as scheduled.

_____ Initial: You MAY contact me by phone and/or leave a message for appointment reminders or to notify me of a doctor/therapist cancellation.

- Preferred number: _____
- Alternative number: _____

Please note: If we need to contact you, we will first try to do so at your preferred number and then only utilize your alternative number if needed (e.g., unable to reach you) or otherwise directed (e.g., change of preferred number).

Informed Consent
Your below signature indicates that you have read and understand the above information and agree to these terms as part of your treatment at Advanced Clinicians Specialty Services.

Patient Signature: _____ Date: _____
(or Parent/Guardian signature if Patient under 18 years of age)

Clinical Provider Signature: _____ Date: _____