Strength of Life Counseling Services

Client Communications

Patient Name: _____ Date of Birth: _____

E-Mail Communication

By providing my email address below, I am authorizing Strength of Life Counseling Services to communicate with me via email.

_____**YES** I authorize Strength of Life Counseling Services to Communicate with me via email.

My email address is:_____

_____**NO** I **DO NOT** authorize Strength of Life Counseling Services to Communicate with me via email.

I understand that the use of email is for my convenience and that I am not obligated to communicate via email. I understand the inherent unsecured nature of email and therefore accept the risks of using email. I also understand that I am responsible for informing Strength of Life of any changes to my email address. I am aware that email messages do not substitute for check-in calls or face-to-face sessions. I understand that I may rescind email consent at any time upon written and signed notification. I understand the inherent unsecured nature of texting and therefore accept the risks of using texting with my counselor. Strength of Life Counseling Services discourages texting between counselor and client due to the unsecure nature of texting, except for appointment issues.

Appointment Reminder System

_____ Please **TEXT** me an appointment reminder to this phone number:

_____

_____ Please **E-Mail** me an appointment reminder to this e-mail address:

_____

_____ Opt-Out. I prefer not to have an automated text or e-mail.

24 Hour Cancellation Policy

All reminder calls made by Strength of Life Counseling Services, either by phone call, text, or e-mail are ***a courtesy for our patients***. It remains patient's responsibility to notify Strength of Life Counseling Services of any need to reschedule or cancel. **Cancellation fees may apply**, per Patient Financial Policy.

Patient Signature: _____ Date: _____