Agreement to Receive Electronic Communication

CMPS
COASTAL MEDICAL & PSYCHIATRIC SERVICES INC.

1. Name:

   First Name Middle Name Last Name

2. Date of Birth:

   MM : DD YY

3. Initial Below:

   I DO Agree

   Initial

   I DO NOT Agree

   Initial

That the business may communicate with me electronically at the email address and/or phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the business any updates to my email address and / or mobile phone number.

4. Most Preferred Method of Communication:

   ☐ Text Message ☐ Email

5. I would Like to Receive:

   ☐ Appointment Reminders

6. Contact Information

   My Email My Phone

I can withdraw my consent to electronic communications by signing a revocation form at:

Coastal Medical and Psychiatric Services
825 Diligence Drive Suite 206 Newport News VA 23606
Phone: 757-310-6900
Fax: 757-240-5936

7. Signature Date of Signature

   MM DD YY

*Please remember that text and email reminders are a courtesy and not a guarantee. Patients or their parent/guardian are fully responsible for keeping track of and remembering scheduled appointments.