Riverview Psychiatry, LLC
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Phone: 423-443-2120
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Consent to Email or Text Usage

Name of Patient: _____

Name of Parent/Guardian if Pt Under 18: _____

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Riverview Psychiatry.

_____ (Patient initials) I consent to receive text messages from Riverview Psychiatry at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

_____ (Patient initials) The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is: _____

_____ (Patient initials) The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is: _____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient/Parent Guardian Signature_____

Date_____