Email Communication Consent Form

I hereby acknowledge that I have requested the opportunity to communicate by email. I understand that in communicating in this manner, I am exposing myself to certain risks that may include:

- The privacy and security of email communication cannot be guaranteed
- Employers and online services may have a legal right to inspect and retain emails that pass through their systems
- It is impossible to verify the true identity of the sender or to ensure that only the recipient can read the email once it has been sent
- Emails can introduce viruses into a computer and potentially damage/disrupt the computer
- Email is indelible; even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or in cyberspace
- It is the policy of New Roots therapy to respond to emails within one business day. If the patient's email requires or invites a response from Dr. Lisa Smith, ND and the patient has not received a response within one business day (with the exception of posted out-of-office notifications), it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond
- The patient is responsible for informing Dr. Lisa Smith, ND of New Roots Therapy of any types of information the patient does not want sent via email

Dr. Lisa Smith, ND and staff at New Roots Therapy will use reasonable means to protect the security and confidentiality of email information sent and received; however because of the risks just outlined, Dr. Lisa Smith, ND and New Roots Therapy cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct.

No new diagnosis will be communicated via email. Patients should not use email for medical emergencies or other time-sensitive matters. Email communication is not an appropriate substitute for clinical inquiry, examinations or a thorough assessment by the ND; it may be required that the patient's questions or concerns be addressed through an in-office visit, which if required, will be communicated to the patient by Dr. Lisa Smith, ND.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication by email between Dr. Lisa Smith, ND of New Roots Therapy and myself. I consent to communicating by email with Dr. Lisa Smith, ND in spite of these risks.

Date: ____________________ (MM/DD/YYYY) Patient Email: ______________________________________

Patient Name (please print): _________________________________ Signature: _______________________

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