Schuylkill Medical Associates, LLC®
"Charting a new course in geriatric home care."

MEMBER CONTACT FORM

1. I, _____, give permission to Dr. Pluta and the Program to communicate with me as indicated on this form.

2. I authorize Dr. Pluta to contact me by the following methods (check all that apply):

☐ Text Message: _____
Mobile

☐ E-mail: _____
E-mail Address

☐ Phone: _____ _____
Mobile Home

3. When Dr. Pluta or the Program communicate with me by text message or e-mail, as indicated on this form, they may freely discuss topics of any nature, including any reference to or discussion of my protected health information (check one):

☐ Yes

☐ No

☐ Yes, but with the following restrictions: _____

_____

_____

_____

4. Security of Protected Health Information.

- I understand that any communications with Dr. Pluta and the Program via e-mail or text message (whether initiated by me or initiated by Dr. Pluta or the Program) are not secure.
- Dr. Pluta and the Program do not guarantee the security of such communications, they are not responsible for any unauthorized access to the communications by any third party, and I will have no claims against Dr. Pluta or the Program for such instances of unauthorized access.
- I have been advised of the risk that protected health information in e-mails and text messages is not secure and could potentially be accessed by a third party.
- I understand that I have the right to change my communication preferences at any time by updating this Member Contact Form.

Signature of Patient: _____ Date: _____

Printed Name: _____

OR

Representative for Patient:_____ Date:_____

Printed Name:_____

Relationship to Patient:_____