TAMPA INSTITUTE FOR
PAIN & SPINE

TIPS Email or Text Contact Agreement

Tampa Institute for Pain and Spine
13140 Elk Mountain Dr. Ste B, Riverview, Fl 33579
(813) 513-TIPS (8477) Office, (813) 574-7761 Fax **www.InstituteforPainandSpine.com**

Dear _____

Thank you for choosing Tampa Institute for Pain and Spine (TIPS) for your healthcare needs. It has been our pleasure to serve you and the Tampa/St. Petersburg Community.

Recently, CMS (Centers for Medicare/Medicaid Services) has issued initiatives for physicians to demonstrate meaningful use of of their Electronic Medical Records in order to enhance and improve patient communication with their physicians through technology. Study after study have shown a link between engaged communication and better health outcomes. Engaged and informed patients are more likely to adhere to medical advice, keep appointments and monitor their conditions, which make the patient an important addition to the healthcare team.

In an effort to provide the best possible patient experience in the most effective and efficient manner, TIPS will begin utilizing technology to make or remind patients of their upcoming appointments, notify our patients of test results and provide other educational communications to our patients. We are therefore requesting you to complete the bottom portion of this letter, providing TIPS with your email address and cell phone number. By returning this signed and completed form to our office, you are agreeing to allow TIPS to contact you by email and/or cell phone/text message. ***TIPS, in no way will distribute your private contact information to any third party and will only utilize this information for notification from TIPS.***

We appreciate your cooperation and look forward to continuing to provide you the highest quality of care.

Sincerely,

Tampa Institute for Pain and Spine
Physicians and Staff

****

_____ _____
Email Address Mobile Telephone Number

I Authorize TIPS to contact me through email and/or mobile/text for future communications

_____ _____
Signature of Patient/Representative DATE