**Blood Pressure Management Texting Program**

**Consent Form**

Northeast Valley Health Corporation (NEVHC) can send text messages to your cell phone to help you better manage your blood pressure and remind you about the next Blood Pressure Management Class.

Taking part in this service is voluntary. If you would like to participate in this service, please read and sign this consent form. Your consent to participate starts from the day that you sign this form and ends automatically in 6 months. You may choose to stop participating at any time by texting the word “STOP” in response to a text message sent by NEVHC or calling the message line at 1(818) 270-9508. If you decide to withdraw from this service, you will not lose any benefits or rights to which you are entitled to.

Please keep in mind that this program does not replace the advice of a doctor. If you have any questions about your medical care, you should contact your doctor’s office or your care coordinator. In case of an emergency, call 911.

**Possible Risk & Cost Involved:** NEVHC is not responsible for cell phone carrier charges. You may be billed for the cost of the text messages used in this program. Please check with your cell phone provider for more information. Please keep in mind that if you lose or share your phone, someone else might see your text messages.

I have read this consent form and fully understand it’s benefits, risks, and possible costs. I voluntarily give NEVHC, or those authorized by NEVHC, my consent to participate in the Blood Pressure Management Texting Program. I agree to receive text messages from NEVHC regarding this program.

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language Preference: Spanish or English (please circle one)