WATSON CLINIC LLP

Quality Healthcare for Every Generation

Automated System OPT-IN Consent For Telephone Calls, Voicemail Transmissions, Recorded Messages and SMS/Text Messages

By signing this agreement, you expressly consent to receive and authorize Watson Clinic LLP ("the Clinic"), its affiliates, business associates, and service providers to deliver, or cause to be delivered, telephone calls including telephonic sales calls, text messages, or voicemail transmissions using an **automated system for the selection or dialing of your phone number or the playing of an artificial voice or pre-recorded message**. This could result in charges to you according to your phone plan. These calls and messages will be for health care and other purposes including but not limited to, for the purpose of treatment, appointment reminders and office closure announcements, clinic operations, telemarketing and advertising possible treatment alternatives and other health-related benefits and services that may be of interest, and for the purpose of servicing your account, payment and billing, and collecting any amounts you may owe.

If at any point you change or obtain a new phone number, or if you no longer maintain the phone number you originally provided to us, you agree to notify the Clinic immediately of such change by completing the Automated System OPT-OUT of Consent form at **www.WatsonClinic.com/Text**. If you do not have internet access, you agree to notify the Clinic immediately of such change in writing at the following address: **1600 Lakeland Hills Boulevard, Lakeland, FL 33805, attention: Director of Reception Services**. You agree to provide your full name, address, date of birth, and Clinic number in your notification.

You may be held liable for failure to do so, as outlined in the following provision:

Indemnity Provision - *READ CAREFULLY*:

You agree to indemnify and hold the Clinic, its officers, agents and employees harmless from any liability, loss or damage, including but not limited to, attorney's fees, they may suffer as a result of claims, demands, costs or judgments against them arising out of alleged violations of the Telephone Consumer Protection Act, Florida Telemarketing Act, or similar laws, resulting from the use of automated systems for the selection or dialing of telephone numbers, playing of artificial or pre-recorded messages placed to an incorrect or reassigned phone number(s), originally belonging to you or which you provided to the clinic, but of which you failed to timely notify the Clinic that such number(s) was incorrect or no longer assigned to you.

Opt-In

I, _____ authorize and expressly consent to receive calls and
(PATIENT NAME)

messages to my phone number: _____ placed by the Clinic, its affiliates,
(PATIENT CELL PHONE NUMBER)

business associates, and service providers, using an automated system for the selection or dialing of my phone number or the playing of an artificial or pre-recorded voice message or for text messages or voicemail transmissions, for health care and other purposes, including treatment, appointment reminders and office closure announcements, clinic operations, telephonic sales calls, telemarketing and advertising possible treatment alternatives and other health-related benefits and services that may be of interest, and for servicing my account, payment and billing, or collecting amounts I may owe. I agree to notify the Clinic immediately if I change or obtain a new cell phone number, or no longer maintain the cell phone number provided herein, and expressly acknowledge that I may be held liable for failure to do so, as outlined above.

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I understand that I need not directly or indirectly sign this form or agree to enter into such an agreement as a condition to purchase any goods or services and such messages and phone calls carry certain risks. For example, messages may be sent in unencrypted form. They could be received by others if others have access to my device or if my messages are sent to another device. I understand the risks, and I expressly consent to receiving these messages and ask the Clinic to communicate with me in this form.

I have read this disclosure in its entirety and agree that the Clinic, its affiliates, business associates and its service providers may contact me as described above.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

DATE OF BIRTH CLINIC #

_____

LEGAL REPRESENTATIVE PRINTED NAME IF SIGNING FOR PATIENT (PARENT/GUARDIAN OF MINOR)

DESCRIPTION OF AUTHORITY TO SIGN FOR PATIENT: _____