Dina M. Lomas, LCSW
1728 Jonathan Street, Suite 204
Allentown, PA 18104
610-698-2852
www.dinamlomaslcsw.com

Communication Consent Form

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, please review/ complete and sign this Communication Consent Form.

I, _____, authorize Dina Lomas, LCSW to contact me and/or named authorized person(s) and to convey PHI by the following methods and assume responsibility to notify Dina Lomas, LCSW whenever information changes.

Home Mail:	Yes ____		No ____
Home Telephone:	Yes ____	#: _____	No ____
Home Voicemail:	Yes ____		No ____
Work Telephone:	Yes ____	#: _____	No ____
Work Voicemail:	Yes ____		No ____
Cell Phone:	Yes ____	#: _____	No ____
Cell Phone Voicemail:	Yes ____		No ____
Fax:	Yes ____	#: _____	No ____
Email:	Yes ____	Address: _____	No ____

Who may be contacted in case of an emergency?

Name: _____ Relationship: _____

Phone Numbers: _____ _____

Please list names of other people authorized to receive information about your care:

Spouse: _____ Parent: _____

Other: _____ Other: _____

Client Signature Date

Parent/ Guardian Signature (needed if patient is less than 14 years of age) Date

The following is information about communicating with the office. Please read and sign:
The contact number for **Dina Lomas, LCSW** is **610-698-2852**.
Messages left on this voicemail are confidential. Please feel free to leave information on voicemail and I will respond as soon as I am able. My voicemail will also advise of times when I am away from the office. In any event if you have an emergency situation and I do not answer and you get my voicemail, please call 911, your county crisis intervention office (Northampton 610-829-4801 or Lehigh 610-782-3127) or utilize your nearest hospital emergency room.
You can text this number to schedule, change, or confirm appointments ONLY. Please make certain to identify yourself when doing so. **Do Not** use text messaging to discuss your clinical information or for emergency purposes. Thank you.

Client Signature Date

Parent/ Guardian Signature (needed if patient is less than 14 years of age) Date

A copy of this document will be provided to you upon request.