PATIENT'S COMMUNICATION PREFERENCES

In order to reach our patients regarding services and financial obligations, we will use all methods of communication you provide below to expedite that communication. By providing this information, I agree that Warner Park Surgery Center, its legal agents, or affiliates may use the telephone numbers and email address(es) provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Warner Park Surgery Center, its legal agents, or affiliates may contact me via email notification regarding my care, our services or my financial obligation,

I recognize that text messaging is not a completely secure means of communication because messages can be accessed improperly while in storage of intercepted during transmission. The text I receive may contain my personal information. By signing the consent below, I authorize you to contact me via text message. I also agree to update you promptly if my mobile phone number changes. I understand that I am not required to authorize you to use text messaging and a decision to not sign this portion of the authorization will not affect my care in any way.

I consent to receive text and/or email messages:

_____
Parent or Patients Signature

WHAT'S THE BEST NUMBER TO REACH YOU AT:

Home #: _____ Work #: _____

Cell #: _____ Other: _____

CAN WE SEND MAIL TO YOUR HOME ADDRESS? Y _____ N _____

ANY OTHER FAMILY OR FRIENDS YOU WOULD LIKE US TO BE ABLE TO SHARE YOUR HEALTH CARE OR FINANCIAL INFORMATION WITH OTHER THAN YOUR INSURANCE COMPANY OR YOUR HEALTH CARE PROVIDERS?

Name: _____ Phone: _____

Name: _____ Phone: _____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information. I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____
Patient or Personal Representative Date

_____ _____
Printed Name Relationship to Patient

PT LABEL HERE