How Can We Reach You?

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

NAME (PLEASE PRINT) _____
HOME PHONE NUMBER _____
WORK PHONE NUMBER _____
CELLULAR PHONE NUMBER _____
EMAIL ADDRESS _____

HealthONE Clinic Services
PHONE MESSAGE CONSENT

In an effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will **NOT** leave messages with anyone except the patient or legal guardian.
- We will **NOT** leave any confidential information on an answering machine.
- We will **NOT** leave any message on a voicemail.

UNLESS
WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, _____ give HealthONE my permission to speak with and/or leave phone messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My Home answering machine: #_____ Initials____
My Cell answering machine: #_____ Initials ____
My Office/Work voice mail: #_____ Initials ____
My Spouse/Guardian: Name_____ # _____ Initials ____
Other:
If other: Name: _____

_____ _____
Signature Date