Patient Consent To Receive Mail and/or Telephone Message

PLEASE FILL OUT THE ENTIRE FORM. THANK YOU.

Office@NozDoc.com www.NozDoc.com

Please print (Last Name) _____ **(First Name)**_____ **(M.I.)**___

To confirm your appointment the day before Y_____ N_____

Send test results to your home Y_____ N_____

PLEASE CHECK THE AREA BELOW THAT APPLIES, SO THAT WE MAY CALL YOU!!!!!! THANK YOU

Call and/or leave the information on your Cell Phone/Voice mail:		**Email:**
Appointment information	Y_____ N_____	Y_____ N____
Billing information	Y_____ N_____	Y_____N____
Medical information	Y_____ N _____	Y_____N____

Call and/or leave the information on your home answering machine/voice mail:

Appointment information	Y_____ N_____
Billing information	Y_____ N_____
Medical information	Y_____ N _____

Call and/or leave the information on your work answering machine/voice mail:

Appointment information	Y_____ N_____

Please list anyone you would like to share access to your private information. If you do not list your spouse, child, etc., we will not be able to speak with them on your behalf.

I give permission to share appointment information with the person(s) named below:

Name: _____

I give permission to share medical information including biopsy and lab results with The person(s) listed below:

Name: _____

I give permission to share billing information with the person(s) listed below:

Name: _____

Signature of Patient/Guardian/Parent: _____ **Date:** _____

Patient's Home # _____ **Patient's Cell#** _____

Patient's Email: _____