Permission of Patient Contact

Contact Information: This information will allow this office to contact you with appointment reminders or other information relevant to billing or treatment.
Please fill out the bottom portion in its entirety.

Please list two phone numbers that we may use to contact you:

1. Phone #: _____ 2. Phone #: _____

In the event that Dr. O'Desky or her associate is unable to reach you concerning your status with this office (i.e. appointment, test results, billing statements, etc.) may we leave a message on your:

Home answering machine Yes _____ No _____
Cellular voice mail Yes _____ No_____
Work voice mail Yes _____ No_____

If I need to contact you at work and you are unavailable, may I leave a message with the receptionist for a call back to my office? Yes No

Please list the names of any person or persons that may be involved in your treatment that I may be permitted to discuss anything concerning your medical status (i.e. practitioner, spouse, partner, parent, etc). Please note, if a name is not listed, I am required by law to protect your information and I will not discuss anything pertaining to your healthcare with that unlisted person.

Name: _____
Phone number

Name: _____
Phone number

Name: _____
Phone number

Patient Name: _____ Date: _____/__ /_____

Signature: _____ Relationship: _____
(Parent or Guardian if patient is under 18 yrs old)

Please **note that effective April 14, 2003, **the law** requires a written **notice for any changes or additions to the information** that you have listed above. Any verbal **communication of changes or additions will not** be honored by our **office.**