

Consent to Contact Patient

I, _____ by providing my land line, cell number, and/or email address, expressly consent to receiving communications from _____, your staff, or your contractors, including collection agents, and to any land line, cell number, email, or other electronic communication I provide or that you later acquire for me. You may use this information to contact me live or leave voice mail, text, email or pre-recorded messages regarding my account(s) and/or healthcare service(s) provided to me. Providing you with my contact information is not a condition of receiving healthcare services.

I consent to being contacted by (check all that apply)		
	Yes	No
Land line Phone	<input type="checkbox"/>	<input type="checkbox"/>
Cell number	<input type="checkbox"/>	<input type="checkbox"/>
Email	<input type="checkbox"/>	<input type="checkbox"/>

By signing this Consent to Contact Patient form, I acknowledge that I have read (or have had read to me) and understand the contents and the consent I am providing, and I agree that this information may be used to contact me live or by voice mail, text, email, or pre-recorded message. I permit a copy of this consent to be used in place of the original.

Patient Signature

Date

Time

Witness Signature

Date

Time

Signature of Guarantor or Legal Representative

Date

Time

