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)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tr>
<td>☐ Land line Phone</td>
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<td>☐ Cell number</td>
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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

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CHI Franciscan Health

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