

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 _____

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 messages on a voicemail

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO

Please read below and consider carefully whom you would 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 by me in writing.

My home answering machine: # _____ Initials _____

My Cell Phone answering machine: # _____ Initials _____

My Office/Work voice mail: # _____ Initials _____

My Spouse/Guardian: # _____ Initials _____

If other: Name: _____

Signature: _____

Date: _____