CONTACT CONSENT

Patient Name: DOB:

Home Phone Number: Alternate Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May our office staff leave any messages on your home answering machine regarding appointments, billing questions or prescription information?

 Yes\_\_\_\_\_ No\_\_\_\_\_

May our staff leave a message at your work place?

 Yes\_\_\_\_ No\_\_\_\_\_

Please list the names of any individuals that our office staff has permission, which is given by you, to speak with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Relationship Phone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Relationship Phone #

Responsible Party PRINT:

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATION CONSENT

Our system is able to pull your prescribed medications directly from your pharmacy when available. Please sign below giving us your consent.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_