**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 _____
EMAIL ADDRESS _____

**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 message on a voicemail.

**UNLESS**
**WE HAVE YOUR WRITTEN PERMISSION TO DO SO.**

Please read below and consider carefully whom you 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 in writing.

My Home answering machine: #_____ Initials____
My Cell answering machine: #_____ Initials ____
My Office/Work voice mail: #_____ Initials ____
My Spouse/Guardian: Name_____ # _____ Initials ____
Other:
If other: Name: _____

_____ _____
Signature Date