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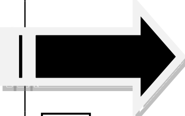
COMMUNICATION CONSENT

HOW WOULD YOU LIKE US TO COMMUNICATE WITH YOU?

Our Chiropractic office sends appointment reminders, information about treatment, payment, insurance and other communications. Please tell us how you would like to communicate with you.

Please Print Your Name: ____

Complete all that apply (please print clearly)



Please specify your Wireless Provider: ____

☐ Contact by text message at the following phone number: ___________________________

☐ Contact me by email at the following e-mail address: _____________________________________

Signature: ____ Date: ______________________

Please inform us promptly if your address, email, or phone number changes!

☐ **We link patients in a household for statement purposes, to show credit and balance in the household. <u>Please initial</u> and sign if you authorize the transferring of credits from account (s) to another account(s) within a household.**

Signature: ____ Date: ______________________

Our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information release to family embers you must sign below. Signing this form will only give information to family members indicated below. I authorize Creekside Chiropractic Center, LLC to release my medical and/or billing information to the following individuals.

1. ____________________________________ **Relation to Patient:** ____________________________
2. ____________________________________ **Relation to Patient:** ____________________________
3. ____________________________________ **Relation to Patient:** ____________________________

Signature: ____ Date: ______________________

06/13/2017 KED