ALLERGY & ASTHMA CARE, INC.

PATIENT COMMUNICATION PREFERENCES AND PERMISSIONS

Please print legibly and return completed form to the receptionist.

Patient Name (First) _____ (MI) _____ (Last) _____

Patient DOB __ __ /__ __ /__ __ __ __

Because we value your right to privacy, we need to know your preferences regarding our communications with you. We routinely call our patients for a variety of reasons, including the following:

- To schedule and confirm appointments
- To discuss lab or test results
- To respond to patient questions and concerns
- To address billing, insurance, or other account issues

If we need to speak with you and you aren't available, what would you like us to do? (Please check all that apply.)

☐ Do not leave information for or about me in an answering machine or voice mail message, or with another person. Leave a name and number and I'll return your call. (If you selected this option, please skip to the bottom to date and sign.)

☐ Leave the information on my answering machine/voice mail at my landline phone number:

Landline Ph (__ __ __) __ __ __ - __ __ __ __

☐ Leave the information on my voice mail at my cell phone number:

Cell Ph (__ __ __) __ __ __ - __ __ __ __

☐ Leave the information with or for any/all of the following contacts:

1. Relationship _____ ☐ Emergency contact only

   Name (First) _____ (Last) _____

   Landline Ph (__ __ __) __ __ __ - __ __ __ __ Cell Ph (__ __ __) __ __ __ - __ __ __ __

2. Relationship _____ ☐ Emergency contact only

   Name (First) _____ (Last) _____

   Landline Ph (__ __ __) __ __ __ - __ __ __ __ Cell Ph (__ __ __) __ __ __ - __ __ __ __

3. Relationship _____ ☐ Emergency contact only

   Name (First) _____ (Last) _____

   Landline Ph (__ __ __) __ __ __ - __ __ __ __ Cell Ph (__ __ __) __ __ __ - __ __ __ __

4. Relationship _____ ☐ Emergency contact only

   Name (First) _____ (Last) _____

   Landline Ph (__ __ __) __ __ __ - __ __ __ __ Cell Ph (__ __ __) __ __ __ - __ __ __ __

If one of the parties listed above contacts us, do we have your permission to discuss your healthcare and account information with them? ☐ Yes ☐ No

Thank you for telling us how best to keep you informed about issues relevant to your healthcare. If any of the information above changes, you are responsible for notifying us of that change. Please request a new form or provide other written and signed notification at that time.

Date __ __ /__ __ /__ __ __ __ **Signature** _____

(For patients under 18 years of age, parent/guardian must sign.)