



**SURGICAL SPINE**  
ASSOCIATES

**www.Surgical-Spine-Associates.com**

## CONSENT TO COMMUNICATE

Patient Name: \_\_\_\_\_

Please mark the ways that you consent to us communicating with you:

Method	OK to leave voicemail	OK to leave message with another person	Preferred contact method(s)	Best time to call
Call Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Call Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Call Home Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Send Email				
Email Appt Reminders	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Email Appt Confirmations	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Email Marketing Info	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Send Regular Mail	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Mail to which address: Home Other (please list):				
Send Text Page	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Text Appt Reminders – if so, list cell carrier:				
Text Marketing Info – if so, list cell carrier:				

If its ok to message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

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