Mercer-Ocean Podiatry, PC

Dr. Frank Killian, DPM, FACFAS *Dr. Sameep Chandrani, DPM, AACFAS*

REQUESET FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: ____

Date of Birth: _______________________

I request that all communications to me (by telephone, mail or otherwise) by Mercer – Ocean Podiatry, P.C., and/or its staff be handled in the follow manner:

1. For **WRITTEN** Communication: Address to:

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2. For **ORAL** Communication: Call Telephone #: ______________________________________

3. For **E-MAIL** Communication: ____

4. I give my permission for Mercer – Ocean Podiatry, P.C. to leave a message on my voicemail.

Signature: ____

Date: ___ /___ / ______

As a patient of Mercer – Ocean Podiatry, P.C., you also have the right to not receive any communication from our office. If you would like to opt out of receiving any form of communication from our office, which includes reminder phone calls, calls from one of our doctors or staff with potential important information, etc., please sign and date below. ***(Only sign below if you have not signed above)***

Signature: ____

Date: ___ /___ / ______

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