

PATIENT ALTERNATIVE COMMUNICATION REQUEST (Please Print)

PATIENT INFORMATION				
Patient's last name:	First:	Middle Initial:	Birth date:	Sex : <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security:	
City:	State:	ZIP Code:	Home phone:	Cell phone:
HEALTH INFORMATION SUBJECT TO ALTERNATIVE COMMUNICATION				
<i>(Describe the kinds of information subject to the request. If everything, say "all information"):</i>				
HOW TO COMMUNICATE INFORMATION				
<i>(Describe the methods for communicating with you below):</i>				
Alternative Phone numbers <i>(include name of contact person if not you):</i>				
Land line and name: ()			Cell Number and Name: ()	
Mailing Address:			Other Method:	
BILLING FOR HEALTH CARE SERVICES				
<i>(Describe how you want us to bill for health care services):</i>				
Address:	City:	State	Zip:	
Other (e.g. Email or Fax):				
NOTICE				
I understand that requesting this alternative method of communication may interfere with the health care practitioner's ability to contact me in medical emergencies. I understand and agree that, if I cannot be located by the alternative method requested, the practitioner may use any available contact information to locate me in the event that (1) the practitioner determines there is a medical emergency or similar situation in which my health is at risk if I am not contacted immediately; or (2) if I have not provided adequate information on how payments for health care services will be made.				
Patient/Authorized signature:				Date:
<i>If signed by person other than patient print Name of Authorized Person and relation to patient and authority to authorize:</i>				
FOR OFFICE USE ONLY				
Date Received:		Date Approved/Disapproved:		
Name and signature of Person who decided this request:				