INTEGRATIVE FAMILY MEDICINE

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PATIENT CONTACT FORM

All patients may request for Integrative Family Medicine to utilize alternative methods (i.e. Written/oral) or alternative locations (i.e.work/home) for correspondence containing protected health information. (PHI). Alternative Family Medicine will honor all reasonable requests and does not require the patient to disclose and explanation/reason for request.

Your physician will at times need to contact you. By filling out the information below, we will be better able to serve you.

NAME:_____ DOB:_____

PHONE: HOME_____ WORK_____ CELL_____

ADDRESS:_____ CITY/STATE/ZIP_____

SOCIAL SECURITY #_____ EMAIL ADDRESS:_____

PHONE MESSAGE CONSENT

In an effort to protect your privacy, we have developed a policy on leaving medical care messages: We will NOT leave messages with anyone except the patient or legal guardian. We will **NOT** leave any information on an answering machine. We will **NOT** leave any messages on a voice mail.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO. Please read below and consider carefully whom you want to have access to your medical information.

I,_____, give INTEGRATIVE FAMILY MEDICINE my permission to leave phone messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My Home/Cell answering Machine #_____ Initials_____

#_____ Initials_____

My Office / Work Voice Mail: #_____ Initials_____

My Spouse: #_____ Initials_____

Other: #_____ Initials_____

SIGNATURE_____ **DATE:**_____

CONSENT TO TREAT MINORS

I,_____,give INTEGRATIVE FAMILY MEDICINE permission to treat my child/children without myself (the parent/legal guardian) being present. My child/children's names(s) **AND** date of birth are:

_____ _____

_____ _____

SIGNATURE:_____ **DATE:**_____