

The Peer Group for Plastic Surgery

Patient Contact Authorization Form

Patient Name: _____

➤ **May we contact you in any of the following methods? (please circle)**

Call you at home	yes	no	Leave a message at home	yes	no
Call you at work	yes	no	Leave a message at work	yes	no
Call you on your cell	yes	no	Leave a message on cell	yes	no
Send fax to you at home	yes	no	Send fax to you at work	yes	no

_____ Home fax number

_____ Work fax number

Send e-mail to you at home yes no

Send e-mail to you at work yes no

_____ Home e-mail address

_____ Work e-mail address

Send mail to you at home yes no

Send mail to you at work yes no

➤ **To whom may we speak about your appointments, treatment, insurance or billing?**

_____ appts. treatment billing/insurance
Name

_____ appts. treatment billing/insurance
Name

_____ appts. treatment billing/insurance
Name

_____ appts. treatment billing/insurance
Name

Speak only to me about my appointments, treatment, insurance or billing.

_____ Patient's Signature

_____ Date

[This form is valid for one year unless revoked or changed in writing by the patient.]