The SpineCare Center

DCH

Physician directed treatment and rehabilitation for pain relief.

Request to Communicate

I authorize The SpineCare Center to contact me regarding clinical services in the means provided below. These messages may include appointment reminders, schedule changes or other personal health information. I understand it is my responsibility to notify The SpineCare Center should this information change. **I understand I do not have to provide any of the communication sources.**

Home Phone: _____ ☐ You may leave a detailed message
Ex: 123-456-7890

Cell Phone: _____ ☐ You may leave a detailed message
Ex: 123-456-7890

Work Phone: _____ ☐ You may leave a detailed message
Ex: 123-456-7890

Email: _____ ☐ You may leave a detailed message

Do you give permission for us to contact or leave information with another person?

☐ Yes ☐ No

List name of person: _____

Relationship of person to you: _____

Contact phone number: _____
Ex: 123-456-7890

Signature of Patient/Patient Representative: _____

Relationship of patient representative: _____

Note: Electronic signature not available on this form. Please print out filled form to sign, and bring with you to your next appointment.