Consent to Communicate

ROPER ST. FRANCIS PHYSICAL THERAPY Powered by ATI

Patient Name: _____Today's Date: _____Location:_____

Consent to Communicate Via Email

I understand that authorized personnel from ATI may communicate with me regarding scheduling, the treatment being provided, educational information including newsletters as it relates to health related products or services available at ATI, or alternative treatments, locations or providers. I agree to receive such communication via email at the following email address:

_____

Email address

X_____ X_____

Patient/Guardian Signature Date

Consent to Communicate to Others

I hereby authorize ATI, through its appropriate personnel, to communicate with _____, my (Circle one) husband/wife/mother/father/son/daughter/significant other/friend regarding billing and payment for services rendered on my behalf. I understand that ATI will attempt to verify the identity of those I authorize to communicate regarding billing and payment by way of seeking confirmation of the answers to at least 2 of the following questions:

1. Patient's mother's maiden name is_____.
2. City in which the patient was born_____.
3. Birthday of the patient is_____.
4. Name of patient's current pet is_____.
5. Zip code of the patient's mailing address is _____.