CONSENT TO COMMUNICATE

PATIENT NAME:_____TODAY'S DATE_____LOCATION:_____

CONSENT TO COMMUNICATE VIA EMAIL

I understand that authorized personnel from Peak Physical Therapy 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 Peak Physical Therapy, or alternative treatments, locations or providers. I agree to receive such communications via email at the following email address:

_____

Email Address

_____

Patient/Guardian Signature Date

CONSENT TO COMMUNCATE WITH OTHERS

I hereby authorize Peak Physical Therapy 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 Peak Physical Therapy 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 patient is:_____.
4. Name of patient's current pet is:_____.
5. Zip code of patient's mailing address is:_____.