PATIENT COMMUNCIATION CONSENT FORM

I agree to allow BACK IN BALANCE CHIROPRACTIC and staff to contact me in the following methods regarding my private heath information, evaluation and treatment. I authorize BACK IN BALANCE CHIROPRACTIC to leave detailed messages for me when I am unavailable.

PREFERRED CONTACT NUMBER	***NUMBER/ADDRESS***	***MESSAGE (YES or NO)***	
____ *Home Phone*	***(____) _____***	*Yes*	*No*
____ *Cell Phone*	***(____) _____***	*Yes*	*No*
____ *Work Phone*	***(____) _____***	*Yes*	*No*
____ *Text Messages*	***(____) _____*** ***(Texting requires that you give us your cell number and for you to have a text enabled cell phone plan)***	*Yes*	*No*
____ *Email*	_____	*Yes*	*No*

I authorize BACK IN BALANCE CHIROPRACTIC and staff to discuss my healthcare information (which may be history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	***RELATIONSHIP TO PATIENT***	***CONTACT INFO***
_____		
_____		
_____		

EMERGENCY CONTACT ONLY---

NAME: _____ ***Phone:*** _____

By my signature below lacknowledge that I have read and understand the **Guidelines to Patient Communication** and information provided on this consent form. I understand the risk associated with the different methods of communication and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that BACK IN BALANCE CHIROPRACTIC may impose.

_____

Patient name printed ***Date***

_____

Patient/Authorized Signature ***Relationship to Patient***