Dr. William J. Duke / Dr. Jody P. McAleer

Provider-Patient Contact Consent Form

JCMG PODIATRY

Your physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

I _____, DOB ____/____/_____ give JCMG Podiatry my permission to leave phone messages/voicemails regarding my medical care and test results with the following individual(s) and/or answering systems. The message can include appointment information, test results, billing information, etc. I understand if I choose the option for callback information only, a message will be left solely with a first name and callback telephone number. I am aware that restrictions placed on where messages can be left may impact clinician and staff ability to contact me with important information.

I wish to be contacted in the following manner (check all that apply):

Home telephone number and/or answering machine number:_____

____I consent to messages with detailed information as outlined above.
____Leave messages with first name and callback number only.
____Do not leave messages at my home telephone number.

Mobile/Cellphone number and/or voicemail number:_____

____I consent to messages with detailed information as outlined above.
____Leave messages with first name and callback number only.
____Do not leave messages at my home telephone number.

Work telephone number and/or answering machine number:_____

____I consent to messages with detailed information as outlined above.
____Leave messages with first name and callback number only.
____Do not leave messages at my home telephone number.

I fully understand that this consent will remain in effect until revoked in writing.

Patient Signature:_____ Date:_____