

Patient Name (please print): _____

Date of Birth: _____

Please indicate which of the following numbers you would like for us to use:

Home Phone: _____ Work Phone: _____ Cell Phone: _____
(____) _____ - _____ (____) _____ - _____ (____) _____ - _____

E-mail: _____

Please note, if you supply a cell phone number and/or an email address, you will receive appointment reminders through these methods. You may later opt-out of them if you wish.

What is your preferred communication method? Email Phone Text

In an effort to guard your privacy, please answer the following questions on how best to contact you regarding communication from Midwest Eye Care/Midwest Eye Surgery Center (MEC).

In regards to messages left on voicemail or an answering machine, you authorize your doctor or staff (*please choose one*):

- To leave messages regarding your medical condition(s), as well as appointment reminders, billing/ financial questions, and requests to call the office.
- To leave only messages regarding appointment reminders and requests to call the office. Do not reference your medical condition(s) in the message.

If you wish to allow MEC staff to discuss your protected health information with a person(s) you appoint, please fill out the sections below.

- MEC may share medical, billing, and appointment information with the following individuals:
 - Spouse or significant other: _____
 - Son(s) or daughter(s): _____
 - Any relative: _____
 - Other (nursing home, friend, caregiver, etc.): _____

Authorization

I understand I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed.

Signature

Date