CONSENT TO COMMUNICATE

Patient Name: _____ Today's Date: _____

Consent to Communicate Via Email

I understand that authorized personnel from Changes Plastic Surgery & Spa may communicate with me regarding:

- Scheduling
- Treatment being provided
- Education information
- Pre-Operative packets and Consents

I agree to receive such communication via email at the following email address:

_____
Email Address

_____ _____
Patient Date

Or via text at the following mobile number: _____

Consent to Communicate to Others

I hereby authorize Changes Plastic Surgery, through its appropriate personnel to communicate with:

_____,
Print Full Name of Contact

My (circle one) husband / wife / mother / father / son / daughter / significant other / friend

Regarding:

___ Billing ___ Treatment
___ Payment ___ Scheduling

I understand that Changes Plastic Surgery & Spa will attempt to verify the identity of those I authorize to communicate regarding billing, payment or/and treatment by way of seeking confirmation of the answers to at least 2 of the following questions:

Patient's mother's maiden name: _____Birthday of the patient is: _____

City in which the patient was born: _____ Name of Patient's current pet is _____

Zip Code of the patient's mailing address: _____

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