# COMMUNICATION FORM

**All fields marked with a * are required.**

Do **NOT** disclose or discuss any information related to my billing account or medical conditions with anyone except myself, except in an emergency situation.

o I Agree

**Please list any person(s) we may contact and indicate (by checking the box) if we may discuss any information related to your billing account, and/or medical conditions. Also, choose the person you would like us to list as your emergency contact in the event an emergency situation was to take place in our office.**

**Contact person 1**.
*Name Last:_____ *First : _____

*Relationship:_____ *Phone:_____

*Contact approved for: o Billing account information o Medical condition Information o Emergency

**Contact person 2**.
*Name Last:_____ *First : _____

*Relationship:_____ *Phone:_____

*Contact approved for: o Billing account information o Medical condition Information o Emergency

**Contact person 3**.
*Name Last:_____ *First : _____

*Relationship:_____ *Phone:_____

*Contact approved for: o Billing account information o Medical condition Information o Emergency

**Contact person 4**.
*Name Last:_____ *First : _____

*Relationship:_____ *Phone:_____

*Contact approved for: o Billing account information o Medical condition Information o Emergency