

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

NAME OF PATIENT: _____

DATE OF BIRTH: _____

I REQUEST THAT ALL COMMUNICATIONS TO ME (BY TELEPHONE, MAIL OR OTHERWISE) BY ASSOCIATES IN FOOT AND ANKLE CARE, INC. AND /OR ITS STAFF BE HANDLED IN THE FOLLOWING MANNER:

FOR WRITTEN COMMUNICATION:

ADDRESS TO: _____

FOR ORAL COMMUNICATION:

CALL: _____ TELEPHONE NUMBER

MAY WE LEAVE A MESSAGE? ___ YES ___ NO

IF THE ADDRESS PROVIDED ABOVE IS NOT YOUR HOME ADDRESS OR IS NOT A STREET ADDRESS,PLEASE PROVIDE US WITH A STREET ADDRESS FRO THE PURPOSES OF ENSURING PAYMENT:

PATIENT SIGNATURE

DATE