PREFERRED CONTACT METHOD

Please complete the information below to help update our records.

Patient Name: ____

Our default method of contact to notify you of your appointment reminders, recalls, general notices, medical issues and portal notifications is **EMAIL**. Please list the appropriate person to receive these notifications.

Contact Person: _____________________________

Relationship to Patient: ________________________

Email address: ____

** **If you DO NOT want to receive an email notification, you may choose an alternate method. Please update your preferred method of contact.**

Contact person: _____________________________

Relationship to Patient: _____________________

Phone Number: ______________________________

Method of contact preferred. Choose only one option.

- ☐ Home phone voice message
- ☐ Cell phone voice message
- ☐ Text message

Our default method of receiving billing statements is mail. You have the option to receive e-Statements by registering at **https://pay.instamed.com/caringhandspediatrics**.

I understand that I am personally responsible for being aware of dates and times of my scheduled appointments. Caring Hands Pediatrics provides reminders to appointments out of courtesy. We request that cancellations are made 24 hrs. in advance. You will receive a charge of $25.00 for any missed appointment.

I hereby consent to the above contact methods from Caring Hands Pediatrics.

Signature of Parent: _____________________________ Date:___________________________