CONTACT CONSENT FORM

Date __________________

Name ____

Phone (   ) ____ *(Is this cell or home or both?)*

Email____

How do you preferred to be contacted?

□ Phone
□ Text
□ Email

Can we leave a message or a voicemail?

□ Yes
□ No

What are your preferences? *(please check the boxes below)*

	Cell Phone	Text	Email
Appointment Reminders			
Appointment Scheduling			
Appointment Rescheduling			
Appointment Cancellations			
Billing and Payments			
Events			
Newsletters			

I hereby authorize Twin Rivers Physical Therapy Clinic to the above terms of the Contact Consent Form. At any time, I have permission to add, modify or discontinue a mode of communication with Twin Rivers Physical Therapy.

Patient Signature ____ Date __________

Parent or Guardian Signature ____ Date ___________
(If the patient is under the age of 18)