CHANCE CHANGE

WELLNESS SPA

Patient Contact Authorization

PLEASE NOTE THAT CHANCE TO CHANGE DOES NOT DISCLOSE OR SELL ANY PATIENT PROTECTED HEALTH INFORMATION TO ANY THIRD-PARTY BUSINESS OR ONLINE DATABASE.

I, the undersigned, authorize Chance to Change to contact me according to the policies of Practice regarding facets of my care, including requests for information, verification of payment or benefits, and reminders for appointments. I understand and accept that Practice may leave messages on home or cell phone answering systems or send reminder cards by U.S. mail, email, or text message, according to the policies of Practice.

If Practice needs to communicate with me regarding my treatment, my preferred method of communication is as follows (check one):

☐ Phone call _____ ☐ Email_____

☐ Text Message _____ ☐ Other _____

I understand that if I have chosen a phone call as my preferred method of communication, Practice may be required to leave a voicemail for me regarding my treatment. In such an event, Practice should (check one):

☐ Leave a message with detailed information regarding my treatment.

☐ Leave a message requesting that I call Practice at a specified phone number.

I understand that, from time to time, Practice may utilize email or text messages to communicate with me both about my treatment and for marketing purposes. I understand that these emails or text messages may include appointment reminders, general health reminders, feedback requests, newsletters and other information relating to Practice. Accordingly, I (check one):

☐ Authorize Practice to email or text me for both treatment and marketing purposes.

☐ Authorize Practice to email or text me appointment and health reminders only.

☐ Do not authorize Practice to email or text me.

I understand that this authorization will remain in effect until I either submit a subsequent Patient Contact Authorization changing my above stated preferences, or I revoke or withdraw this authorization in writing. To do so, I must send written notice to Practice at c2cmedspa@gmail.com.

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I acknowledge and agree that Chance to Change and its employees, officers and physicians are released from any legal responsibility of liability for or resulting from the authorized disclosure of my health or billing information.

Printed Patient Name **Date**	**Signature of Patient**
Practice Representative Name	**Signature of Practice Representative/Witness**