Patient Statement Email Request

Provider/Therapist:_____ Today's Date:_____

Patient Information

Patient's Name:_____ DOB:_____

Parent/Guardian's Name:_____

Street Address:_____

Phone: ( )_____ CP#: ( )_____

Email (Please Print Clearly):_____

Patient Statements are sent 1 time per month. By filing out this form and signing below you are acknowledging that you want your monthly Patient Statement to be sent electronically to the email address provided and not to your mailing address via the United States Post Office.

By signing below I certify that the information provided on this form is current and correct to the best of my knowledge. I authorize my Provider to send my patient statements to the email address listed above. In choosing this feature I understand that my patient statement will no longer be mailed to my mailing address on file, but will be sent electronically to the email address I provided above. If at any time my email address changes I understand that it will be my responsibility to update that information with my Provider's office. If at any time I wish to discontinue my statements being sent to my email address listed above, I will submit in writing a request to turn off this feature.

_____ _____

Patient Signature/Guardian Signature (if Patient is under 18 years of age) Date