

ATWOOD FAMILY MEDICAL CENTER

Chesapeake Executive Family Care

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APPOINTMENT VERIFICATIONS OFFICE ANNOUNCEMENTS PATIENT SURVEYS

By supplying my home phone number, mobile phone number, email address and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointments(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the numbers provided by me.

Home Phone Number _____

Cell Phone Number _____

Email Address _____

Patient Name (printed) _____ DOB: _____

Patient Signature: _____ Date: _____

Parent or Guardian's Signature: _____ Date: _____

Relationship to Patient: _____