

Total Patient Care, LLC

459 Jack Martin Blvd.

Brick NJ 08724

Patient Phone / Voice Mail Consent Form

I hereby give consent for Total Patient Care, LLC ("*the Practice*") to communicate with me by the communication method listed below unless I "opt out" now or in the future.

Telephone/Cellular Phone

I hereby give my consent for *the Practice* to call me by phone at the phone number(s) provided below and to leave voice messages and/or to leave a message with the person answering the phone. These messages may be a reminder of my previously booked appointment date and time, or a notification that I need to make an appointment for a medication review, a payment reminder, or other message regarding care provided to me by *the Practice*.

I have requested that *the Practice* communicate with me via the method listed above as it is much more convenient for me to obtain updates and messages via such communication method. I acknowledge that *the Practice* does not have any obligation to provide any messages or updates to me via the communication methods listed above or by any other means in connection with appointment reminders or any information.

I acknowledge that there is no assurance that any such voice message will be transmitted in a secure manner

Phone Number ofor Calls/Voice Messages: HOME: _____ CELL: _____

"Opt Out" of Policy

In addition to the above, *the Practice* may communicate with the following persons regarding my health information

Name: _____ Tel: _____ Relationship: _____

Name: _____ Tel: _____ Relationship: _____

Patient or Guardian

Date

ALL Patients have the right to change their minds and have this service stopped. If you no longer wish to receive these messages as set forth above, please notify *the Practice* in writing. If you change your cellular number or home number provided above, please inform us so that we can update our records.