Grove Medical Associates, PC

Primary Care Center of Excellence

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Patient Contact Consent Form

First Name ____ Last Name ____ Middle Initial ____ Date of Birth ____ Today's Date ____

I consent and agree that Grove Medical Associates, P.C. may contact me in regards to laboratory results, outside testing results, financial information and appointment information at the following telephone numbers:

Home Phone Number: ____________________
- ☐ OK to leave a message with detailed information

Cell Phone Number: ____________________
- ☐ OK to leave a message with detailed information

Work/Alternate Phone Number: ____________________
- ☐ OK to leave a message with detailed information

My Preferred Phone Number: ☐ Home ☐ Cell ☐ Work/Alternate

Current Mailing Address: ____________________

I consent that Grove Medical Associates, P.C. may contact and leave a message with the following person in regards to laboratory tests, outside testing results, financial information and appointment information.

First Name ____ Last Name ____ Relationship to Patient ____ Phone # ____

I understand and agree to the terms above and acknowledge that the information provided is accurate and complete.

Patient or Authorized Person's Signature ____ Date ____

Electronic Health Maintenance Communication Policy

Grove Medical Associates, P.C. will periodically send electronic communications regarding health maintenance reminders. Please indicate your preferences below:

My Preferred Communication Method: ☐ Phone call ☐ SMS Text Message (will use cell phone) ☐ Patient Portal Message

My Preferred Phone Number: ☐ Home ☐ Cell ☐ Work/Alternate

My Current Email Address: ____________________

My Preferred Time of Day for Contact: ☐ Morning ☐ Afternoon ☐ Evening

By signing below, I understand the Grove Medical Associates, P.C. Electronic Health Communication Policy and agree to receive periodic health maintenance communications from Grove Medical Associates, P.C.

Patient or Authorized Person's Signature ____ Date ____