Aestique® Plastic Surgical Associates, Ltd.

CONSENT TO COMMUNICATE

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

Method	OK to leave voicemail	Ok to leave message with another person	Preferred contact method(s)	Best time to call
Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Send Email				
Email Appt Reminders	☐ Yes ☐ No			
Email Medical Info	☐ Yes ☐ No			
Email Marketing Info	☐ Yes ☐ No			
Send Regular Mail	☐ Yes ☐ No			
Mail to which address: Home Other (please list):				
Send Text Page	☐ Yes ☐ No			
Text Appt Reminders – if so, list cell carrier:				
Text Marketing Info – if so, list cell carrier:				

If its ok to message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Signature: _____ Date: _____