

CENTRAL EYE CARE

Patient Communication Consent Form

Patient Information

Patient Name: _____

Date of Birth: _____

Date: _____

At Central Eye Care, we are committed to keeping you informed about your eye care in a way that is convenient and respectful of your privacy. This form allows you to tell us how you would like to receive communications, including messages about appointments, billing, results, and other health-related updates.

By checking "Yes" below, you authorize Central Eye Care and its service providers or partners acting on its behalf to communicate with you using the selected methods.

1. Phone Calls (Including Voicemail)

☐ Yes, I consent to receive phone calls and voicemails from Central Eye Care or services acting on its behalf.

☐ No, I do not consent to receive phone calls or voicemails.

Preferred Phone Number: _____

2. Text Messages (SMS)

☐ Yes, I consent to receive SMS text messages from Central Eye Care or services acting on its behalf. I understand that standard message and data rates may apply.

☐ No, I do not consent to receive SMS messages.

Mobile Number for Texts: _____

3. Email

☐ Yes, I consent to receive emails from Central Eye Care or services acting on its behalf. I understand email is not a fully secure communication method and messages could potentially be accessed by unintended

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parties.

☐ No, I do not consent to receive emails.

Email Address: _____

Important Notes

- You can update or revoke your communication preferences at any time by notifying our office in writing.
- Central Eye Care will never sell your contact information.
- These messages may be automated.

Acknowledgment

By signing below, I acknowledge that:

- I have reviewed my communication preferences above.
- I understand the risks associated with electronic communication.
- I give my consent for Central Eye Care and its service providers to use these methods to contact me.

Patient or Guardian Signature: _____ Date: _____

Staff Use Only:

Entered into system by: _____ Date: _____