INTERMED
Care without compromise.

Patient Communication Form

Patient's Legal Name: _____ **Date of Birth:** _____
First MI Last (preferred)

Parent(s)/Legal Guardian(s) *(minor patients only):* _____

Mailing Address: _____
City/State/Zip Code

E-mail Address: _____
By providing my email address I understand I will be enrolled in a MyInterMed patient portal account. This service is offered to patients over the age of 18 and to the parents of pediatric patients under the age of 13. *Check this box if you do NOT want to be enrolled in the patient portal.* ☐

Primary Coverage

Insurance Name:_____ **Subscriber ID:**_____ **Group #:** _____

Secondary Coverage

Insurance Name:_____ **Subscriber ID:**_____ **Group #:** _____

Phone Contacts	**Circle One**	**Circle One**
(preferred)* (_____) _____ ☐Home ☐Cell ☐Work	**Okay to leave message?** Yes / No	**Extended Message**?** Yes / No
(secondary)* (_____) _____ ☐Home ☐Cell ☐Work	**Okay to leave message?** Yes / No	**Extended Message**?** Yes / No

**Minor patients only: please note which number belongs to which guardian if multiple guardians listed.*

***Extended messages may contain medical and/or prescription information*

I agree to receive follow up surveys by an automated dialing service and/or an artificial or prerecorded voice, and/or text messages to my telephone number or cell phone number provided during my registration process.
Check this box if you do NOT want to receive follow up surveys via cell phone. ☐

Emergency Contact Name: _____ **Relationship**:_____

Emergency Telephone: (_____) _____ (_____) _____ (_____) _____
Cell Home Work

Please specify your preference for routine <u>verbal</u> communication to family/caregivers by checking boxes below:

❖ The following information may be <u>verbally</u> communicated to the family/caregivers listed below:

Prescription Request ☐ Request/Confirm/Cancel Appointments ☐ Referral Request ☐

Name:_____ Name:_____ Name:_____

OR

❖ ☐ I do **<u>NOT</u>** want any information about my healthcare communicated to family/caregivers.

This authorization should be updated every 12 months. This authorization will remain current until an updated version is received or this version is revoked in writing. I understand I have the right to revoke this authorization in writing at any time. Revocation will not cover information that has already been released. **I understand that I will need to complete InterMed's Authorization to Release Health Care Information form or provide an equivalent HIPAA compliant authorization if I wish to allow my provider to discuss health information not covered by the categories listed above.**

_____ _____
Patient/Parent/Legal Guardian Signature **Date**