INTERMED
Care without compromise.

Patient Communication Form

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

Mailing Address: _____
City State Zip Code

E-mail Address: _____

Parent(s)/Legal Guardian(s): *(only if patient is a minor)* _____

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**
(____) _____ ☐ Home ☐ Cell ☐ Work	Okay to leave message? Yes / No	**Extended Message? Yes / No
(____) _____ ☐ Home ☐ Cell ☐ Work	Okay to leave message? Yes / No	**Extended Message? Yes / No

**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 (___) _____

Select One:

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

☐ **I give InterMed permission to verbally communicate to family members/caregivers listed below.**

Name: _____ **Name**: _____ **Name**: _____

Please check the box next to the specific information that may be **<u>verbally</u>** communicated to the individual(s) listed above:

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

This authorization will be updated every 12 months. I have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. If I want to grant permission to InterMed to discuss any other information, including AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone besides myself, I understand that I will need to complete a separate Release of Information form.

_____ _____
Patient/Parent/Legal Guardian Signature Date