Kara Wallace, MD, PC

CONSENT TO CALL AND OR TEXT

Patient Name: _____

Mobile / Phone Number: _____

Phone number(s) must be provided

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from Kara Wallace, MD, PC, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time. I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by and automated dialing system.

○ ACCEPT

○ DECLINE

Automated messaging Preferences:

Health Notifications	____ email	____ phone	____ text
Appointments	____ email	____ phone	____ text
Announcements	____ email	____ phone	____ text
Billing Issues:	____ email	____ phone	____ text

Preferred method of contact:

____ Home Phone ____ Mobile Phone

____ Work Phone ____ Mail

_____ _____/_____/_____

Signature Date