VOICE MAIL CONSENT FORM

I____________________________ consent to information being left voice mail regarding appointments, treatment(s), and billing.

Numbers approved for voice mail contact :

Home Phone: ____

Cell Phone: ____

Work Phone: ____

Contact Person(s): ________________________ ________________________

Name(s) **Phone number**

Yes, I approve ________________________

Patient signature

No, I do not approve ________________________

Patient signature

Date: ________________________