

MEMBER



AMERICAN SOCIETY OF
PLASTIC SURGEONS

JAMES W. WADE, M.D., F.A.C.S.

PLASTIC SURGERY CONSULTANTS



MEMBER
THE AMERICAN SOCIETY
FOR AESTHETIC PLASTIC SURGERY

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

Patient Name: _____

Do we have your permission to:

Call you/send mail to your *home*? Yes _____ No _____
 If yes, may we leave the following information on your home answering
 machine/voice mail?
 Appointment information Yes _____ No _____
 Billing information Yes _____ No _____

Call you at *work*? Yes _____ No _____
 If yes, may we leave the following information on your work answering
 machine/voice mail?
 Appointment information Yes _____ No _____
 Billing information Yes _____ No _____

I give my permission to share appointment information with the person(s) listed below:

Name: _____

Relationship: _____

I give my permission to share billing information with the person(s) listed below:

Name: _____

Relationship: _____

Patient Signature

Date