Northwest NeuroSpecialists, PLLC
Communication Preference

Patient's Full Name:_____

Date of Birth:_____ MRN_____

Your Preferred Method of Communication

We're pleased you've chosen Northwest NeuroSpecialists to provide your health care. In order to provide you with the best possible customer service we would like to know how you would like us to communicate with you. The following information will assist us in contacting you with any lab, radiology, test, procedure or communication from your care team. **Your preference will remain effective until you notify us of any changes.**

HIPAA privacy rules give you the right to request a restriction on uses and disclosures of your protected health information (PHI). By signing this document, you agree, restrict or object to providing PHI to family members, friends or caregivers.

Northwest NeuroSpecialists usually sends labs, radiology, test or procedures results to your home address by mail. Sometimes we will call you about your results or to set an appointment to discuss them with the appropriate provider. If we call, we will make an attempt to get in touch with you according to your request as indicated below. This communication agreement also includes inquiries on your health care via telephone, mail and email.

The best number(s) to reach me by telephone Monday through Friday, 8:00 a.m. to 4:30 p.m.

____Home **____ Ok to leave a message with detailed information**

____ Leave a message with callback number only

____ Do not leave a message

____ Cell **____ Ok to leave a message with detailed information**

____ Leave a message with callback number only

____ Do not leave a message

_____ Other **____ Ok to leave a message with detailed information**

____ Leave a message with callback number only

____ Do not leave a message

If we have permission to share your information with anyone else, in case we cannot reach you by phone, please fill in their name and telephone number below:

____Ok to disclose lab, radiology test, or procedures results info only

____Ok to discuss and disclosed any/all clinical information

___ Spouse:_____ Phone #_____

___ Parent:_____ Phone#_____

___ Other:_____Relationship:_____ Phone#_____