CONTACT AUTHORIZATION

Patient Name: ____ Birth Date:_________________

Home Phone: (____) ________ - ___________

Cell Phone: (____) ________ - ___________

Please indicate your preference(s) with a check mark below for Home Phone / Cell Phone:

☐ Leave Message/lab/test/results/med changes ☐ Only the people listed below

☐ Do not leave a message of any kind

Work Phone: (____) ________ - ________

Please indicate your preference(s) with a check mark below for Work Phone:

☐ Leave Message/lab/test/results/med changes

☐ Do not leave a message of any kind

Email Address: ____

Please indicate your preference with a check mark below for Email Address:

☐ Okay to e-mail appointment reminders.

☐ Do not email reminders

Responsible Party/Guarantor Information:

Name:____

Date of Birth: ___________________________ SS#:______________________________

Employer: ______________________________ Phone:___________________________

Please indicate below anyone who is authorized to talk with Doctor/Nursing/Staff regarding the patient's health care.

NAME	PHONE	RELATIONSHIP

I have verified all the above information and have given my consent to contact me as noted in this document.

Patients/Guardians Signature:

X____ Date: _____________________

Beyond Care Pediatrics, LLC
16945 Frances St, STE 200B
Omaha, NE 68130

Phone: (402) 991-5690
Fax: (531) 600-6282
Web: www.beyondcarepeds.com