|  |  |
| --- | --- |
| Agreement to Receive Electronic Communication | Icon  Description automatically generated |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. | Name: |  |  |  |  |  |
|  |  | First Name |  | Middle Name |  | Last Name |
| 2. | Date of Birth: |  |  |  |  |  |  |
|  |  | MM |  | DD |  | YY |  |  |  |  |  |
| 3. | Initial Below: |
|  | I DO Agree |  |  |
|  |  | Initial |  |
|  | I DO NOT Agree |  |  |
|  |  | Initial |  |
| That the business may communicate with me electronically at the email address and/or phone number listed below.I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the business any updates to my email address and / or mobile phone number. |
| 4. | Most Preferred Method of Communication: |
|  |[ ]  Text Message |[ ]  Email |
| 5. | I would Like to Receive: |  |  |
|  |[ ]  Appointment Reminders |[ ]  Information Regarding Billing |
|  |[ ]  Requests for Customer Satisfaction reviews |  |  |
| 6. | Contact Information |  |  |
|  |

|  |  |
| --- | --- |
| My Email |  |

 |  | My Phone |  |
| **I can withdraw my consent to electronic communications by calling / emailing:**hmauck@mauckmedicalclinic.com785-677-3930 |
|  |  |  |  |  |
| 7. Signature |  |  | Date of Signature |  |  |  |  |  |
|  |  |  |  | MM |  | DD |  | YY |