Associates in Mental Health, S.C.

Established 1981

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AUTHORIZATION FOR APPOINTMENT REMINDER SERVICE

Name of Patient _____DOB_____

Address_____

I hereby authorize Associates in Mental Health to contact the below selected in order to remind me of upcoming appointments.

PLEASE CHECK:

☐ Telephone: _____

☐ Text: _____

☐ Email: _____

☐ I elect not to receive an appointment reminder

If the above number/address changes, I understand that it is my responsibility to contact Associates in Mental Health and change my information so it does not get delivered to an unauthorized party.

Associates in Mental Health schedules appointments by a block of time for each patient. **If you are unable to attend your scheduled appointment, we reserve the right to charge the full office fee for any late notice cancellations or missed appointments.** Your insurance will generally not cover this charge. If you have any questions regarding this policy, please discuss them with your clinician.

I understand that only information regarding my future appointments will be delivered, and that my information will not be given to any third party.

_____/_____ _____/_____
Patient/Legal Guardian Signature Date Witness Signature Date