FOUR PEAKS NEUROLOGY

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Communication Request

Name of Patient: ____

Date of Birth: __________ ________, __________
Month Day Year

I request that all communications with me by telephone, mail, or otherwise by **Four Peaks Neurology, P.C.** and/or its staff be handled in the following manner.

For Written Communications:

____
Street Address

______________ ______________ ______________
City State Zip Code

For Oral Communication:

Phone Number: ______________________ May we leave a message: ◎ Yes ◎ No

If the address provided above is not your home address or is a P.O. Box, please provide us with a street address for purpose of ensuring payment:

______________________ ______________
Patient Signature **Date**

______________________ ______________
Parent Signature if Patients a Minor **Date**

______________________ ______________
Authorized Representative Signature* **Date**
(*if applicable)