Jennifer Buys, Lac., LMT
927 NW Grant Avenue
541-231-5282

Communication Consent Form

This office communicates electronically with patients. When needed, this office will also correspond with other healthcare entities and billing services. That communication process will be electronic, if possible.

However, the practice will not transmit any personal or confidential information about a patient's health, procedures or account status without the patient's permission.

This office may employ the help of an outside service for phone calls, email, and scheduling. They also do not collect or transmit information without consent.

I give my consent that Jennifer Buys, Lac., LMT may contact me electronically by the email address and/or cell phone number listed below for the purpose of receiving appointment reminders, notifications, health records, or other communications. I also give my consent for chart notes to be provided to a billing service in order to submit claims to an insurance company, if applicable.

I understand that during the transmission of communications with me, the information may pass through a public network and onto a personal electronic device. I understand that, during the transmission process, the information may not be 100% secure as it crosses networks.

I agree to inform the practice if my email address or cell phone number changes. I understand and acknowledge that I can cancel this consent at any time.

Email address (please print clearly): _____

Cell phone number (for text messaging or phone calls): _____

Patient signature: _____ Date: _____

Do you give us permission to leave messages on these devices, such as appointment times, billing information, etc.? _____Yes _____ No

Jennifer Buys, L.Ac., L.M.T.
927 NW Grant Avenue
Corvallis, OR 97330
(541) 231-5282

Insurance Information

Name of Patient _____ Date of Birth_____

Address _____

City_____ State _____ Zip _____

Phone (day) _____ (eve) _____

Social Security Number _____

Name of Insured _____ Date of Birth _____

Insured's Social Security Number _____

If auto accident: Date of injury _____ State _____

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Name of referring Physician _____

Name of Insurance Company _____

Address _____

City _____ State _____ Zip _____

Group / Claim Number _____

Representative _____ Phone _____

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By signing below, I authorize the release of any medical information needed to process this claim and the payment of medical benefits directly to the provider. In case of nonpayment by insurance or settlement, I am fully responsible for all costs incurred.

Signed _____ Date _____