SOUTHERN ORTHOPEDIC SPINE SURGERY DR. GAISER

ACKNOWLEDGEMENTS & CONSENTS

Privacy Practice:

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

No Show fee: I understand that if I am unable to keep a scheduled appointment and do not give at least a 24 hour notice that I will be charged a fee. $50 for New Patients and MRI/CT follow ups & $25 for routine follow up appointments.

_____ _____

Patient Name (PLEASE PRINT) Patient Signature Date

Mobile/Cell Phone:

Our computer system has the ability to send out text notifications of upcoming appointments

and emergency closings of the office. If you choose yes, at any time you can choose to opt out.

Do you consent to receive these notifications via text on your mobile phone?

(please circle one) YES NO

Do you consent for our office to call your mobile phone?

(please circle one) YES NO

Medication History Authority:

If you consent then our office can download your medication history for the last 13 months. By allowing us to do this it helps with patient care & treatment allowing for us to have up to date accurate medication information from medication name, dosage/strength and how often it is taken (once a day, twice a day, at bedtime, etc.)

Do you consent for our office to download your medication history?

(please circle one) YES NO

Patient Portal: On the portal you can request appointments, medication refills and ask questions to the staff.

Do you wish to register for our patient portal? (please circle one) YES NO

If you choose YES then we need your email:_____