

Four Peaks Neurology

A Professional Corporation

Communication Request

Name of Patient: _____

Date of Birth: _____, _____, _____
Month Day Year

I request that all communications to 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 not a street address, 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*
(*if applicable)

Date