NON-SURGICAL SOLUTIONS FOR AN ACTIVE LIFESTYLE

# REQUEST FOR ALTERNATIVE MEANS OR LOCATION FOR CONFIDENTIAL COMMUNICATIONS

*Patient Name:* _____ *Medical Record Number:* _____

*Date of Birth:* _____ *Phone Number:* _____

*Patient Address:* _____

I request an alternative means or location of confidential communications to me from Flexogenix, Inc. in the following alternative location or manner (please be as specific as possible).

_____

_____

_____

I understand that Flexogenix, Inc. is **not** required by law to accept my request, but will make every effort to accommodate reasonable requests for alternative means of communication. If alternative means of billing have been requested, Flexogenix, Inc. may request information as to how payment will be handled before accommodating the request.

I understand that if this request is accepted and put into place, it may make Flexogenix, Inc. ability to communicate with me more difficult and/or less effective.

_____ _____ _____

*Signature of Patient or Authorized Representative* *Date* *Time*

If signing as authorized representative, describe authority to act for patient and submit documentation showing such authority: _____

**FLEXOGENIX, INC. USE ONLY**

*Date request received:* _____

*Circle one:* Accepted Denied

*If denied, state reason for denial:* _____

*Method used to communicate decision to the patient:* _____

*Signature of staff member:* _____ *Date/Time:* _____

*Staff Member (Print Name):* _____