MR #:____(office use only)

Emerald Coast Pediatric

Sleep Consultants, LLC

Emerald Coast Pediatric Sleep Consultants, LLC

TELEPHONE CONSUMER PROTECTION ACT (TCPA) DISCLOSURE

Patient Name: ____

DOB: ____

Parent Name: ____

I agree, in order for the practice to service my account or to collect monies I may owe, (practice name), and/or your agents may contact me by telephone at any telephone number associated to my account, including wireless telephone numbers, which could result in charges to me.
You may also contact me by text messages and by email using the email address I provided.
I understand methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, if applicable.

I/we have read this disclosure and agree that (practice name), the practice's employees and/or agents, may contact me/us as described above.

____ ____________________

Responsible Party Signature Date