



ALLERGY ASTHMA
AND SINUS CENTERS

www.allergyasthmasinuscenters.com
info@allergyasthmasinuscenters.com
(815) 729-9900

Consent form for Messages

PATIENT NAME _____ **FULL NAME**

DATE OF BIRTH: MM - DD - YYYY

It is the policy of this office to call you to confirm or reschedule an appointment or to notify you of a missed appointment. We will also notify you when any laboratory results have come in. If you have not heard from our office within 21 days of having the test completed, please contact our office.

Check all acceptable options of notification when contacting the patient

Who we may leave a message with:

- ☐ Patient only
- ☐ Spouse
- ☐ Parent
- ☐ Guardian

Answering machine or voice mail:

- ☐ Home
- ☐ Work
- ☐ I will call you

Please notify our office of any changes in the above information.

X SIGNATURE OF PATIENT (PARENT IF A MINOR)

DATE: MM - DD - YYYY

At our discretion, we reserve the right to charge for appointments cancelled or broken without a 24 hours advanced notice.

Joliet

2228 Weber Road
Crest Hill, IL 60403
Phone: (815) 729-9900
Fax: (815) 729-9913

Aurora

3965 75th Street Ste 101
Aurora, IL 60504
Phone: (630) 375-0087
Fax: (630) 375-6151

Bolingbrook

542 E. Boughton Rd
Bolingbrook, IL 60440
Phone: (630) 972-5800
Fax: (630) 972-3255