SHERBONDY'S
PSYCHIATRIC SOLUTIONS

225 Adley Way – Greenville, SC 29607
(864) 987-9747 – (864) 987-9770

APPOINTMENT REMINDER CONSENT
Phone / Email

I, _____ **give** **Shane Sherbondy, MD**
Patient Name (Print) Physician Name (Print)

And members of his/her staff working at the location indicated above and or automative phone system, my permission to call me prior to an appointment to remind me of appointment date and time.

I would prefer to be called at (check all that apply)

□ Home: _____

□ Work: _____

□ Cell: _____

Yes, this office may leave (check all that apply)

□ Voice mail at my home
□ Messages with people at my home
□ Voice mail on my cell
□ Voice mail at my work
□ Message with people at work
□ Email correspondence

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last if / while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during my treatment. This Consent will expire 365 days after I complete my treatment, unless the physician specified above is notified by me.

_____ _____
Signature of Patient (or Patient's Legal Representative) Date

_____ (Office Staff)
Witness Initials