FLEXOGENIX, INC.
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): _____