



# LIBERTY LAKE

## DIRECT PRIMARY CARE

**CONSENT TO EMAIL AND TEXT COMMUNICATION  
ACKNOWLEDGEMENT OF POLICIES AND PRACTICES**

Patient Name:		DOB:	
Home Address:			
City:		State:	Zip Code:
Email Address:		Cell Phone:	
City and Country of birth			
Alien registration number (A-number) (if any):			
USCIS online account number (if any):			
Interpreter's name (if any):			
I acknowledge that by providing my cell phone number and email address, I am consenting to non-secure methods of communication. I have read and acknowledge the information in Appendix A and Appendix B.			
Signature:		Date:	
If for minor child, name of child:			