Newnan Vascular Center

PATIENT REGISTRATION & SMS OPT-IN CONSENT FORM

Welcome to Newnan Vascular Center. Please complete the information below.
All information is kept confidential in accordance with our Privacy Policy.

1. PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

Mobile Phone Number: _____ Other Phone Number: _____

Email Address (optional): _____

By providing your mobile phone number, you agree that it is a valid number that can receive text messages.

2. SMS (TEXT MESSAGE) COMMUNICATIONS CONSENT – OPTIONAL

Newnan Vascular Center offers patients the option to receive text (SMS) messages about their healthcare. Consent is completely voluntary. You do not have to agree to receive text messages to receive medical treatment or rervices.

☐ Yes, I voluntarily agree to receive SMS (text) messages from Newnan Vascular Center at the mobile phone number provided above. I understand these messages may include, but are not limited to:

- Appointment confirmations
- Appointment reminders
- Scheduling updates
- Procedure preparation instructions
- Office notifications
- Other healthcare-related communications

Message frequency varies. Message and data rates may apply.
Reply STOP at any time to opt out. Reply HELP for assistance.
Consent is not a *condition of purchase or receiving medical treatment*.

If you do not wish to receive SMS messages, you do not need to check this box.

3. HOW WE HANDLE YOUR INFORMATION

We respect your privacy. Your information will only be used to communicate important healthcare-related messages you have agreed to receive. We will never sell or share your mobile number for marketing purposes. For more details, please review our Privacy Policy and Terms & Conditions.

Privacy Policy: https://newnanvascular.com/privacypolicy

Terms & Conditions: https://newnanvascular.com/terms

4. HELP & SUPPORT

Need help? Reply HELP in any message, call us at **(678) 423-4100,** or visit https://newnanvascular.com.

5. PATIENT ACKNOWLEDGMENT

By signing below, I confirm that I am the patient or the authorized representative of the patient and that the information provided is accurate.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

You may opt out of SMS messages at any time by replying STOP.
For help, reply HELP or call (678) 423-4100.
Standard message and data rates may apply.