



Interventional Pain Management/Anesthesia

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: in emergency situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including family, friends, previous treating physicians, your family doctor (PCP), and other doctors/specialist) with whom we may share your information:

NAME

RELATIONSHIP TO PATIENT

What is the best phone number for us to contact you? WK HM CELL OTHER

Phone number: _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voicemail, or with another individual in your absence. Is it OK for such message to include details (such as diagnosis and medication information) at this number?

Signature of Patient or Legal Representative

Date

Print name of Patient or Legal Representative

Relationship to patient

Regards,

Nelson Bond MD

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