NYU Langone
MEDICAL CENTER

FACULTY GROUP PRACTICE CELL PHONE CONTACT FORM

I understand that, as a service to its patients, NYU School of Medicine provides appointment reminders, bill pay reminders and other important reminders that may be placed using a prerecorded message. By providing my cell phone number and signing below, I consent to receiving such calls at this number. I understand that I may opt-out at any time by providing notice at the address below.

NYU Langone Physician Services
PO 415662
Boston, MA 02241

_____ _____

Patient Signature **Date**

_____ _____

Guarantor Signature **Date**

Form Revised: 9/27/2016