2730 Pierce St Ste 202, Sioux City, IA, 51104
Phone 712-423-5218 ✦ Fax 712-202-5389
By Dr. Tammy Sue Rhea-Bohnenkamp DDS

Patient Communication and Recording Consent

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Communication Consent

I authorize **Siouxland Sleep Solutions** to contact me regarding my appointments and care through:

☐ Text Messages (SMS)

☐ Phone Calls

☐ Email

These communications may include appointment reminders, confirmations, scheduling changes, and other information related to my care.

I understand that message and data rates may apply and that I may withdraw my consent at any time by notifying the office.

Recording Consent

To help ensure accurate documentation of my care, I authorize **Siouxland Sleep Solutions** to record virtual visits, and/or in-office discussions when necessary for clinical documentation and healthcare operations.

☐ I consent to recording for documentation purposes.

☐ I do not consent to recording.

Signature

By signing below, I acknowledge that I have read and understand this form and consent to the options selected above.

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____

Relationship to Patient (if applicable): _____