Synergique Healing, PA

Behavioral Health & Functional Medicine

Update Emergency Contact Request

Patient Name:_____ Date of Birth_____

Request: ____Remove ____ Add _____ Update

Emergency Contact Full Name:_____

Relationship to patient:_____

Phone Number:_____ Email:_____

Home Address:_____

City/State/Zip:_____

Request: ____Remove ____ Add _____ Update

Emergency Contact Full Name:_____

Relationship to patient:_____

Phone Number:_____ Email:_____

Home Address:_____

City/State/Zip:_____

_____**Opt. Out Option:** Would like to not have an emergency contact at this time.

By signing below, I acknowledge that I read, understand and consent for Synergique Healing, PA to update my emergency contact information as requested and can be changed at any given time upon my written request to do so.

Signature:_____ Date:_____

(Patient or Guardian if patient a minor)

Relationship to patient (if minor):_____

8703 Meadowcroft Dr. Houston, TX 77063 P# 713-840-7956 Fax:281-972-8349

Email: admin@synergiquehealing.com https://synergiquehealing.com/