Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization creates and maintains health records describing my health history, symptoms, examination and test results. As well as diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and clinical information to my bill
- A means by which a third-party payer (e.g. insurance carrier) can verify that services were actually provided
- And a tool for routine healthcare operations such as assessing quality and outcomes.

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

(*Notice of Privacy Practices* is posted in our office and on our website)

_____   _____   _____
Signature/Guardian   **Relationship to patient**   **Date**

_____
Please print patient's name

_____   _____
Witness   **Date**

Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis. This also may include treatment plan, prognosis, payment and health care operations.

   _____

   _____

   _____

2. Please list family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

   Name: _____ Relation _____ Phone _____

   Name: _____ Relation _____ Phone _____

   Name: _____ Relation _____ Phone _____

3. Please print the address you would like your billing statements and/or Correspondence from our office to be sent if other than your home.

   Street _____

   City _____ State _____ Zip _____

4. Please print the telephone number where you want to receive calls about your appointments, labs and ex-ray results or other health care information.. This may include surgery scheduling information, post operative instructions and notification that pathology results are available.

   Phone (_____)_____   **I am fully aware that a cell phone is not a secure and private line**

   Alternate Phone (_____)_____

5. Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail? ❒ yes   ❒ no

   PATIENT NAME _____ **(GUARDIAN IF UNDER 18)**

   _____ **DATE** _____
   PATIENT/GUARDIAN SIGNATURE