HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any , whom we may inform about your general medical condition and your diagnosis (including treatment ,payment and health care operations) :

Name: ___________________________ Phone Number: ____________________________
Name: ___________________________ Phone Number:____________________________
Name: ___________________________ Phone Number: ____________________________
Name: ___________________________ Phone Number: ____________________________

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

Name: ___________________________ Phone Number: _____________________________
Name: ___________________________ Phone Number: _____________________________
Name: ___________________________ Phone Number: _____________________________
Name: ___________________________ Phone Number: _____________________________

3. Please print the address of where you like you're billing statements and/ or correspondence from our office to be sent ***if other than your home.*** **(Confidential Communication).**
____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL".** Yes: ______ No: ________

5. Please print the telephone number or email address where you want to receive calls about your appointment , lab and x-rays results or health care information ***if other than your home phone number:***
(___)_________________Email Address:___________________@_________

6. Can confidential messages (ie, appointment reminders) be left on your telephone answering machine or voicemail? Yes:__________ No: _________

7. **I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rile of 2013.**

Patient Name: ____________________________ (guardian if under 18 Years)

____ ___________________________

PATIENT / GUARDIAN SIGNATURE **DATE**