HIPPA
ACKNOWLEDGMENT FORM

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and healthcare operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

DATE: _____

PATIENT NAME: (Print) _____

(Signature)_____

WITNESS: _____

HIPPA
PATIENT QUESTIONNAIRE

1. Please list family members or other persons, if any, to whom we may inform about your general medical condition and your diagnosis:

_____
_____

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

_____
_____

3. Please print the address of where you would like your billing statements and /or correspondence from our office to be sent **IF OTHER THAN YOUR HOME.**

_____
_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "**CONFIDENTIAL"**

_____
_____

5. Please print the telephone number, if any, where you want to receive calls about your appointments, labs & X-ray results and any other healthcare information **IF OTHER THAN YOUR HOME NUMBER.**
(_____**)** _____

6. Can confidential messages (i.e. appointment reminders) be left on your HOME answering machine?
Yes _____ NO_____
DATE: _____
PATIENT NAME (Print) _____

If patient under 18 Guardian MUST sign:
Patient/Guardian (Signature) _____