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 the 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 would like your billing statements and/or correspondence from our office to be sent ***if other than your home***. **(Confidential Communications)**

_____

_____

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 appointments, lab and x-ray results or other 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 Rule of 2013.

PATIENT NAME: _____ (guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

OLAYINKA BANKOLE, MDPA	