Patient Consent Form & Questionnaire

Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review your Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
3. The Practice reserves the right to change the Notice of Privacy Policies.
4. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
5. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
6. The Practice may condition treatment upon the execution of this Consent.

This consent was **Signed** by: ____________________________ **Print Name**__________________
Relationship to patient (if other than patient)_________________________ Date_______________

Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):
   ____
   ____
   ____
2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   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. ____
4. Please indicate if you want all correspondence from our office sent in a sealed enveloped marked “CONFIDENTIAL”: YES_________ NO__________
5. Please print the telephone number where you want to receive calls about your appointments or other health care information if other than your home phone number: ________________
6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES _________ NO _________

Patient Name: ____
Guardian Name (if under 18 years of age:) _______________________________

Patient/Guardian **Signature** ___________________________________ Date__________