PATIENT CONFIDENTIALITY QUESTIONNAIRE AND HIPPAA ACKNOWLEDGEMENT

Patient Name: _____ Date: _____

You may be contacted by the practice to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

May we contact you at home? ◯Yes ◯No Telephone (____) _____-_____ Permission to leave voicemail ◯Y ◯N

May we contact you via cellphone ◯Yes ◯No Telephone (____) _____-_____ Permission to leave voicemail ◯Y ◯N

May we contact you at work? ◯Yes ◯No Telephone (____) _____-_____ Permission to leave voicemail ◯Y ◯N

Can a message be left with our company name and what the call is in reference to? ◯Y ◯N

Is there anyone we can leave a message with? ◯Y ◯N.

If yes, please list first and last names and relationship below.

_____
_____

Would you like to authorize an individual as a personal representative? This person would have the authority to schedule, confirm and change appointments only. ◯Y ◯N. If yes, please list first and last names and relationship below.

_____
_____

You have given us your mobile number to communicate with you. We would like your permission to send various promotional specials by text. We will honor your preference. If at any point you change your mind, just let us know. Initial here to opt in _____.

Patient signature: _____ Date:_____

The Parker Center for Plastic Surgery has provided me with a copy of my rights as a patient under the HIPPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

Patient signature: _____ Date: _____

Witness: _____ Date: _____