Patient Privacy Questionnaire (HIPAA)

Physician's Weight Control and Wellness Centers

Name of Patient _____ **Date of Birth** _____

Names and contact numbers of persons, if any, we may contact in an emergency.
(name)_____ (phone #)_____
(name)_____ (phone #)_____

Name of person who has permission to cancel or reschedule appointments for you.
(name)_____ (relationship)_____(date of birth)_____

If you would like correspondence from our office sent to an address other than your home please specify.

_____

_____

Are there any special instructions how correspondence may be sent to you? _____

_____

Please provide an e-mail address we could send correspondence to. _____

**** May we email an appointment reminder to you?** Yes ____ No ____

List the telephone numbers where we may call you. If you do not want to be called at a certain number do not list that number. Cell phones, voicemail, and answering machines are not completely private.

Home Phone _____
May we leave a message on the answering machine? Yes ____ No ____
If someone answers your home phone may we leave a message with that person? Yes ____ No ____

Cell Phone _____
May we leave a message on voice mail? Yes ____ No ____

Work Phone _____
May we leave a message on voice mail? Yes ____ No ____

_____

PATIENT'S NAME (please print) _____

SIGNATURE _____ DATE _____

NOTE: This signed Privacy Questionnaire will remain in your file and considered current. If there are any changes you must notify our office and complete another form.