UNIVERSITY NEUROSCIENCE

HIPAA PATIENT QUESTIONNAIRE

Please bring with you at the time of your appointment

PATIENT NAME: _____ DOB:_____

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 operations).

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

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

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home.

_____

4. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, other health care information if other than your home phone number:

( ) _____

I am fully aware that a cell phone is not a secure and private line.

5. Can confidential messages be left on your telephone answering machine?
Yes _____ No ____

6. I am fully aware my health information will/may be transmitted by electronic transmission, by secure fax transmittal, by internet or by email for continued health care needs.

_____ Date _____

Patient Signature (Guardian if under 18 years)