

Patient Questionnaire and HIPAA Acknowledgement

Patient Name: _____ Date: _____

You **will** be contacted by our facility to remind you of any appointments, healthcare treatment options, billing inquiries or other health services that may be of interest to you. Please select **at least one** mode of communication where we can also leave a voicemail message.

May we contact you at home? **Y/N** Tel.(____)_____ OK to leave voicemail **Y/N**
May we contact you at work? **Y/N** Tel.(____)_____ OK to leave voicemail **Y/N**
May we contact you via cell phone? **Y/N** Tel.(____)_____ OK to leave voicemail **Y/N**
May we contact you via email? **Y/N** email _____

Comment: _____

Can a message be left with our Doctor's name and what the call is in reference to? **Yes/No**

Is there anyone we can leave a message with? Yes/No (if yes, please list first and last names)

If you pursue surgery, who can we discuss information pertinent to your procedure? (Please list first and last name)

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. Yes/No (if yes, please list first and last names)

Patient Signature

Date

Plastic Surgery Services of Fredericksburg, PC has provided me with a copy of my rights as a patient under the HIPAA 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