

TAMPA ORTHOPAEDIC & SPORTS MEDICINE

HIPAA Patient Questionnaire

Please list the family members or other persons, if any, who we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

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

NAME: _____ PHONE #: _____

NAME: _____ PHONE #: _____

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:

Please indicate if you want all correspondence (other than billing statements) from our office sent in a sealed envelope marked "CONFIDENTIAL" YES NO

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or 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.

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES NO

Acknowledgement of receipt of Tampa Orthopaedic & Sports Medicine Group Notice of Privacy Practices.

Please sign your name, print your name, and date on this acknowledgement form. Return the signed acknowledgement to the receptionist.

Patient Name: (Print) _____

Patient Signature: _____

Guardian Signature: _____

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____