PRIVACY NOTICE ACKNOWLEDGEMENT

I received a copy of The Women's Health Group, P.C.'s Notice of Privacy Practices.

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Printed Name

______________________________________ ______________________
Patient Signature Date

**A copy of the Privacy Practices can be found on our website on the Forms page. Signing this acknowledgement confirms you are aware of our Privacy Policy. If you would like a paper copy of our policy, please ask the receptionist.

The Women's HEALTH GROUP, P.C.

PATIENT HIPAA QUESTIONNAIRE AND ACKNOWLEDGEMENT

I have received a copy of the Women's Health Group, P.C's Notice of Privacy Practices.

I. 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:______________________ Phone:______________________

Name:______________________ Phone:______________________

II. 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:______________________

III. 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.

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IV. Please print the telephone number where you want to receive calls about your appointments, lab 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.
- I am fully aware my health information can be transmitted by facsimile (fax), mail, email, or the internet.

V. Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voicemail?

YES________ NO________

PATIENT NAME____

PATIENT SIGNATURE______________________________________

DATE____________________________