BELLA
health + wellness
WOMEN • MEN • CHILDREN

Patient HIPAA Questionnaire

- Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information:

☎ _____

  - Confidential voicemail can be left on this number: ☐ yes ☐ no
  - Confidential text message may be left at this number: ☐ yes ☐ no

- Please provide an e-mail that we can use to communicate with you, and register you for our secure online patient Portal:

 _____

  - Confidential emails may be sent to this provided email: ☐ yes ☐ no

☐ I understand that email is not a secure method of communication **(*please initial*)**

- Please list the family members or other persons, if any, <u>whom we may inform about your general medical condition and your diagnosis</u> *(including treatment, payment and health care operations):*

Name:		**Phone:**	
Name:		**Phone:**	
Name:		**Phone:**	

- Please list the family members or significant others, if any, whom we may inform about your medical condition **<u>ONLY IN AN EMERGENCY</u>**:

Name:		**Phone:**	
Name:		**Phone:**	
Name:		**Phone:**	

- Where you would like billing statements and/or correspondence from our office to be sent?

_____

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**: ☐ yes ☐ no

PATIENT NAME: _____ **DOB:** _____

PATIENT / RESPONSIBLE PARTY SIGNATURE: **DATE:**

_____ _____