



PATIENT REGISTRATION & MEDICAL QUESTIONNAIRE

Patient's Name: _____ Gender: _____ DOB: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail: _____

Occupation & Employer or Date Retired: _____

Race: _____ Ethnicity: _____ Decline to Answer _____

Spouse's Name: _____ Date of Birth: _____ Phone: _____

EMERGENCY: _____ Relation: _____ Phone: _____

Previous Primary Care Physician: _____

Address: _____ Phone: _____

ALLERGIES: (List all types, including medication, latex, foods, iodine, peanuts, eggs, shellfish, etc)

List all medications (including OTC), vitamins and supplements you are currently taking

CURRENT MEDICATIONS	DOSE	FREQUENCY

SURGERIES	YEAR	ANY COMPLICATIONS

Check all that you have completed in the time frame specified

<input type="checkbox"/>	Chest X-Ray in the last 12 months
<input type="checkbox"/>	EKG in last 12 months
<input type="checkbox"/>	Colonoscopy in last 7 years – were any polyps found and removed? Yes or No
<input type="checkbox"/>	Mammogram in the last 12 months (women only)
<input type="checkbox"/>	Pap Smear in the last 12 months (women only)
<input type="checkbox"/>	Eye Exam in the last 12 months



Check all conditions that apply to you

<p style="text-align: center;"><u>GENERAL</u></p> <p>Frequent Fever Weight Loss Decreased Appetite Excessive Fatigue Weakness Weight gain</p> <p style="text-align: center;"><u>EYES</u></p> <p>Wear Glasses Glaucoma Cataracts Discharge Blurry vision Floaters/Black spots Double vision Vision loss Pain with light</p> <p style="text-align: center;"><u>ENT</u></p> <p>Wear hearing aids Trouble Hearing Nose Bleeds Frequent Congestion Inability to smell Sinus Postnasal drip Sore throat / Lumps Mouth sores Hoarseness Difficulty swallowing Change in dentition Ringing in ears</p>	<p style="text-align: center;"><u>RESPIRATORY</u></p> <p>Asthma Emphysema Chronic Pain Chronic cough Shortness of breath Wheezing Bloody sputum Pleurisy Tuberculosis</p> <p style="text-align: center;"><u>GASTROINTESTINAL</u></p> <p>Persistent nausea Vomiting Blood Heartburn Gallbladder problems Hernia Abdominal pain Ulcer / gastritis Change in bowel habits Liver disease Jaundice Diverticulitis IBS/Colitis Hemorrhoids Constipation Diarrhea Blood in Stools Hepatitis</p>	<p style="text-align: center;"><u>HEMATOLOGICAL</u></p> <p>Anemia Bleeding easily Blood clots Persistent swollen glands or lymph nodes Easy bruising</p> <p style="text-align: center;"><u>MUSCULOSKELETAL</u></p> <p>Back problems / Pain Muscle Stiffness / Cramps Joint Pain / Swelling Arthritis General Weakness Osteoporosis Restricted motion / Movement</p> <p style="text-align: center;"><u>INTEGUMENTARY</u></p> <p>Skin disease _____ Rash Itching Dryness</p> <p style="text-align: center;"><u>NEUROLOGICAL</u></p> <p>Fainting/blackout spells Seizures Memory problems Trouble Concentrating Difficulty with speech Unsteady gait Headaches Stroke Numbness/tingling Tremors/hand shaking Eat Salty Foods/Add Salt to food Eat out Frequently</p>
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<p style="text-align: center;"><u>HEAD</u></p> <p>Dizziness Headaches Migraines Past Head Injury Fainting</p> <p style="text-align: center;"><u>CARDIOVASCULAR</u></p> <p>Chest pain/angina High blood pressure Palpitations Heart murmur Chest pain Swelling hands/feet Leg pain while walking Pacemaker</p> <p style="text-align: center;"><u>PSYCHIATRIC</u></p> <p>Feeling Depressed Nervousness Disorientation Mood Change (High/Low) Feeling Stressed Feeling Hopeless</p> <p style="text-align: center;"><u>ENDOCRINE</u></p> <p>Excessive Sweating Thyroid Issues Fatigue Feeling Thirsty Frequent Urination Increased Appetite Goiter</p>	<p style="text-align: center;"><u>GENTOURINARY</u></p> <p>Urinary tract infection Painful/burning urination Blood in urine Frequent urination Kidney stones Excessive urination volume Urine odor</p> <p style="text-align: center;"><u>Males Only</u></p> <p>Prostate Issues Discharge from Penis Curved or Bent Penis Erectile Issues Lack of sexual desire</p> <p style="text-align: center;"><u>Females Only</u></p> <p>Irregular menstrual cycle Menopause Breast Lumps Breast Pain Conduct self breast exams Vaginal Discharge Recent Pregnancy or Pregnant Vaginal Itching Pain during Intercourse Vaginal Dryness Lack of sexual desire</p> <p style="text-align: center;"><u>IMMUNOLOGIC</u></p> <p>Itchy or Watery Eyes Itchy or runny nose Frequent Sneezing Wheezing Congestion Hives</p>	<p style="text-align: center;"><u>SOCIAL HISTORY</u></p> <p>Drink Coffee or Tea Drink Carbonated Beverages Drink Artificial Sweeten Beverage Drink Alcoholic Beverages Natural Fruit/Vegetable Juices</p> <p style="text-align: center;"><i>Which of the above do you consume more than 2 per day</i></p> <p>Coffee or Tea Carbonated Beverages Artificial Sweeten Beverage Alcohol, Beer, Wine Fruit/Vegetable Juices</p> <hr/> <p>Smoke Cigarettes / Cigars Quit Smoking Cigarettes/Cigars</p> <p>Quit When _____</p> <p>Exercise at least 30 minutes/week</p> <p>Type: _____</p> <p>Have a Living Will Advance Directive</p> <p style="text-align: center;"><u>Other known Medical issues</u></p> <p>_____</p> <p>_____</p> <p>_____</p>
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Family History

M O T H E R

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Cholesterol |

F A T H E R

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Cholesterol |
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HIPAA AUTHORIZATION TO REQUEST OR DISCLOSURE PROTECTED HEALTH INFORMATION

Date: _____

- I. **THE PATIENT:** This form is for use when authorization is required to release or request Protected Health Information and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name: _____

Date of Birth: _____

- II. **AUTHORIZATION:** I authorize Trillium Medical Center (TMC) to request **any available** protected health information from current or prior physicians or medical facilities, that will be used in my ongoing medical care. The physicians or facilities below have the most current medical information. **This does not limit TMC from requesting records from other physicians or facilities in the future, if necessary.**

Physician or Facility Name, Location, Phone Number

Physician or Facility Name, Location, Phone Number

- III. **DISCLOSURE:** TMC is authorized to release Medical Records to another physician that I may or have been referred to and is participating in my care. ***This authorization will remain in effect unless I revoke this authorization in writing.***
- IV. **ACKNOWLEDGMENT OF RIGHTS:** I understand that I have the right to revoke any authorization, in writing and at any time, and will be effective from that date forward. I understand that uses and disclosures that have already been made based upon my original permission cannot be revoked.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient physician or facility and is therefore no longer protected by the HIPAA Privacy Standards.

Medical treatment by any party may not be conditioned upon my signing of this authorization (***unless treatment is only to create Medical Records for a third party or to take part in a research study.***)

Signature of Patient (or Representative): _____

Print Name: _____ Date: _____



(COMPLETE ONLY IF SIGNED BY A REPRESENTATIVE)

Reason Patient cannot sign: _____

Authority of Representative to sign: _____

Relationship: Parent Spouse Guardian Other: _____

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

SENSITIVE INFORMATION. If your medical record contains information related to physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion or mental health, a separate consent must be provided.

HIV/AIDS. If your medical record contains information concerning HIV testing and / or an AIDS diagnosis or treatment, separate consent must be provided.

Should my Protected Health Information contain any of the above information, I consent to have all my Protected Health Information released for my continued care. I understand that all Protected Health Information is handled as confidential under HIPPA Privacy Practices that I was provided a copy and signed.

Signature of Patient: _____

Print Name: _____

Date: _____



PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE

Patient Name: _____ **Date of Birth:** _____

At the present time, _____ is my insurance carrier. I will inform Trillium Medical Center PLLC (TMC) of any changes with the above insurance carrier.

As a courtesy, TMC has agreed to file a claim for services rendered with my insurance carrier. I am responsible and required to pay TMC on the date of service for the following:

1. Any co-payment as set by my insurance carrier
2. Any policy deductible or if coverage is terminated
3. Any amount my insurance carrier deems patient responsibility
4. Any amount considered non-covered by my insurance plan

Should TMC not receive payment from my insurance carrier after 45 days from date of service, I may be requested to pay my balance in full and be reimbursed for any payment be received at a later date. I understand that I am responsible for making sure that all charges are paid, and any disagreement or dispute whether covered by insurance or not, will be my responsibility to resolve.

If I am self-pay patient or have a deductible that must be met prior to any insurance payments, I understand that payment is required at the time services are rendered. TMC accepts Cash, VISA, MasterCard, Discover, American Express and Apple & Google Pay.

I understand that any balance is owed after insurance has processed and identified as Patient Responsibility, I am responsible to pay the balance within 30 days of insurance notification or TMC statement received. I may be subject to a “Late Fee” of \$10.00 per month or 1% interest per month (whichever is less) if my account balance is not paid within 30 days of notification.

Any requests for “Special Forms” that are requested to be completed and signed are not part of the services rendered. The fee for these services will vary based on the complexity and expected time required. In most cases it will vary from \$25 to \$100 and must be paid at the time of the request.

I understand that any missed appointments, including same date cancellations, are subject to our **No Show Policy**. If a fee is assessed, payment must be made prior to my next appointment.

Should any balance not be paid as required, I agree that I am responsible for all collection costs, including legal fees and court costs should my account have to be referred to an attorney or collection agency.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY TRILLIUM MEDICAL CENTER.

Patient Signature

Date



No Show Policy

(Includes same day cancellations & arrivals over 15 minutes late)

We understand that unforeseen circumstances can lead to missed appointments, same-day cancellations and late arrivals. To help mitigate this, we utilize an automated reminder system using text notifications and emails. **If a schedule change is needed, you can respond directly to these reminder messages to let us know.**

When timely notifications of schedule changes are received, we greatly appreciate your communication and consideration. Often, with timely notification, we can fill an open time slot with another patient seeking an earlier appointment or consultation with the doctor. However, **when we don't receive notification, it creates an unfortunate gap in the schedule, indirectly affecting other patients who may need an appointment.**

To increase awareness on the importance of timely communication, we have implemented this simple policy that most service businesses have: **If an appointment is not canceled or rescheduled at least 24 hours prior to your scheduled appointment time, or should you arrive more than 15 minutes late for your appointment, a fee may be charged.**

We all know that doctors sometimes run over on appointments as they provide the time and care that all patients deserve. While we strive to stay on schedule, late arrivals impact all patients after your scheduled time. Therefore, in consideration for other patients, **we can only hold your appointment for 15 minutes beyond the scheduled time.** After that, if necessary, your appointment may need to be canceled or rescheduled. **It may be possible to be seen at a slightly later time if another patient arrived early and was able to be seen earlier.**

Related Fees with this Policy

- First Occurrence - **No Fee, reminder only, Credit Card put on file**
- Second Occurrence - **\$25 fee will be charged to your credit card**
- Third or more occurrences - **\$50 fee will be charged to your credit card**

Patient Name (Print)

Signature

____/____/____
Date



Telehealth Informed Consent Information

What is Telehealth?

- Telehealth is a way to visit healthcare providers, such as your physician, nurse practitioner, physician assistant from any place, including your home. You do not have to physically travel to a medical office. Telehealth is a way for you to receive care using telecommunications technology to connect you with your healthcare provider. You can do so from any location where you have access to a device and an internet connection.
- You meet with your healthcare provider via an electronic device such as a phone, computer, or tablet by transmitting audio and video.

Benefits of Telehealth

Virtual visits are growing in popularity for certain situations, but they do not replace in-person office visits for most physician interactions. There are many benefits of telehealth care.

- Limited physical contact reduces everyone's exposure to infectious diseases.
- Virtual visits ensure you get healthcare wherever you are located.
- Virtual visits cut down on travel, time off from work, and the need for childcare.
- Virtual healthcare tools can shorten the wait for an appointment.
- Increased access to specialists who may be located far away from your hometown.

Potential risks for the use of Telehealth

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the clinician providing your healthcare via telehealth.
- Delays in medical evaluation and treatment could occur without physical interaction.
- In very rare instances, security protocols could fail, causing a breach of privacy.
- In very rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- You and your healthcare provider will not be in the same room, so it may feel different from an office visit.
- Your healthcare provider may not be able to make an accurate diagnosis because they cannot examine you as they would in an office visit.
- Your healthcare provider may decide you still need an office visit if they feel that the information obtained via telemedicine was not sufficient to make a diagnosis.
- The video connection may not work, or it may stop working during the consultation.



- The video picture or information transmitted may not be clear enough to be useful for the consultation. Therefore, you may be required to go to the healthcare provider’s office.
- Not all networks are private and secure. It is the responsibility of the patient to ensure that the network and device used by the patient for telehealth services is secure and private.

Will my Telehealth visit be private?

- Telehealth visits are not recorded. Your healthcare provider will take notes as they normally would in our secure electronic medical records system, which is separate from telehealth technology.
- If people are near you, private information may be overheard by others. You should be in a private place, so other people cannot hear you.
- Your healthcare provider will tell you if someone else from their office can hear or see you.
- Trillium Medical Center uses technology that is HIPPA compliant and designed to protect your privacy. However, as with any internet-based communication, there is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try Telehealth and don’t like it?

- Use of Telehealth is a personal choice. You will never be required to use Telehealth and can stop using Telehealth any time, even during a Telehealth visit if you do not feel comfortable.
- Should you choose not to use Telehealth or to stop using Telehealth, your future care or treatment will not be affected.

How much does a Telehealth visit cost?

- What you pay depends on your insurance. A telehealth visit will not cost any more than an office visit. In most cases the same insurance co-pays and deductibles will apply.
- If your healthcare provider decides you need an office visit in addition to your telehealth visit, you will have to pay your co-pay or deductible for both visits.

Why am I signing this document?

You acknowledge that you have read the information in this document. All your questions have been answered should you ever want a telehealth visit. But does not require you to have a Telehealth visit.

Please print your name here

Signature

Date



NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on May 22, 2018, and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes, and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Office. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other people you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013, immunization records for students may be released without authorization (if the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$0.29 for each page and the staff time charged will be \$35 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan, if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.



Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities. Including the disclosure of your PHI in the event of transfer, merger, or sale of the existing practice to a new provider.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes.

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$ 0.29 for each page and the staff time charged will be \$35 per hour including the time required to copy your health information (or \$ 0.54 per page, whichever is less). If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.



QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US: Trillium Medical Center, PLLC
Telephone: 561-736-0881 **Fax:** 561-736-0887 **Email:** office@Trillium-Medical.com
Physical Address: 10301 Hagen Ranch Road, Suite C-180, Boynton Beach FL 33437

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with our Notice of HIPPA Privacy Practices, which states how we may use and/or disclose your protected health information. By signing this form, you acknowledge receipt of this Notice of HIPPA Privacy Practices.

I acknowledge that I read this Notice of HIPPA Privacy Practices (3 pages), and I made a personal copy or requested a copy from Trillium Medical Center after signing.

Please print your name here

Signature _____ *Date* _____

We cannot discuss your protected health information with anyone other than yourself unless you authorize us to do so.

Please list below the name(s) and phone numbers of individual(s) that you authorize our office to discuss your Personal Health Information and care.

You must notify our office in writing of any additions or deletions to this list.

