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|  |  |  |  |  |  |  |  |  |  |  |  |  |  | **PATIENT PRIVACY QUESTIONAIRE** | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **HIPAA ACKNOWLEDGEMENT** | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | **PRESCRIPTION MEDICATION REQUEST CONSENT** | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |
| or other health-related matters. | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Please list any preferred phone numbers: | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Home: | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Cell: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Work: | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Other: | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Can we leave a message at the above numbers? | | | | | | | | | | | | | | | | | |  |  |  |  |  | Yes | |  |  | No | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Are there any restrictions with regard to our office contacting you with medical information? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |
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| Would you like to authorize an individual(s) as your personal representative? This person would have the authority | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |
| to schedule, confirm or change appointments only. | | | | | | | | | | | | | | | | | | |  | Yes | |  |  | No | |  | N/A | |  | If yes, please list full names: | | | | | | | | | | |  |  |  |  |
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| I agree that my prescription medication history may be requested from other healthcare providers or third party | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |
| pharmacy benefit payors and used for treatment purposes. | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Patient or Personal Representative Signature | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  | Date | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| SelectSKinMD has offered me 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. | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Patient or Personal Representative Signature | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  | Date | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |