

PATIENT PRIVACY QUESTIONNAIRE
HIPAA LIFETIME ACKNOWLEDGEMENT
PRESCRIPTION MEDICATION REQUEST CONSENT

Name: _____

Date: _____

You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, or other health related matters.

Please list any preferred phone numbers:

Home: _____

Cell: _____

Work: _____

Other: _____

Can we leave a message at the above numbers?

Yes No

Are there any restrictions with regard to our office contacting you with medical information?

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:

I agree that my prescription medication history may be requested from other healthcare providers or third party pharmacy benefit payers and used for treatment purposes.

Patient or Personal Representative Signature

Date

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.

Patient or Personal Representative Signature

Date