CONFIDENTIALITY QUESTIONNAIRE

Print Patient Name: _____ Date of Birth: _____

Print Guardian Name: _____ Relationship to patient: _____

Please list below family/friend, if any, whom we may inform about your care, treatment, medical condition, and payment. We ask that **no more than two (2) people** be designated as the **contact people**. The names and telephone numbers of your contact people will be listed below and this sheet will become a part of your medical record. Your contact people may contact First State Orthopaedic at (302) 644-3311 during business hours (7:30 a.m.-4:30 p.m.) and the call will be returned as soon as possible. It is important for our staff to maintain your confidentiality; therefore, we will not give detailed information about you unless you have requested us to do so and then only to your contact individuals named below. To protect your confidentiality, your contact people will be asked to provide us with the password you indicate below. **All other persons who request information about you will be referred to your contact people**. This system has been designed so that you can participate in your care and determine your own spokesperson. We are aware that your family and friends are concerned about your welfare and progress. **Please inform them to call your contact people for information about you**.

Please print below the address of where you would like your billing statements (For example, if there is any balance remaining after your insurance company has paid, any deductibles not met, co-pays not paid, or if you have no insurance) and/or other correspondence:

Billing Statement address: ☐ Mail to my home address listed on file

☐ Other address: _____

_____

Correspondence address: ☐ Mail to my home address on file

☐ Other address: _____

May we contact you at work to remind you of appointments, lab results, etc.? ☐ Yes ☐ No

I agree that the email address I provided may be used to generate a patient portal account with First State Orthopaedic. **Patient/Guardian Initials:** _____

I acknowledge receiving a copy of the **NOTICE OF PRIVACY PRACTICES** detailing how my medical information may be used and disclosed in compliance with the Department of Heath and Human Services in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and outlining my rights regarding my medical information.

Patient/Guardian Initials Indicating Receipt: _____

I acknowledge I am designating the below person (s) to be involved in my healthcare and allow them to sign on my behalf for goods/services **Patient/Guardian Initials:** _____

Contact Person #1: _____ Password: _____

Relationship: _____Phone No: (home)_____(work) _____

Contact Person #2: _____ Password: _____

Relationship: _____Phone No: (home)_____(work) _____

Signature:_____ Date: :_____
(Patient or Guardian)

Date Reviewed:_____ Intials:_____ Date Reviewed:_____ Intials:_____ Date Reviewed:_____ Initials:_____