Place Patient Sticker Here

PATIENT QUESTIONNAIRE AND HIPAA ACKNOWLEDGEMENT

Patient Name:_____ **Date:** ____/____/_____

Home Phone: _____**Work Phone:** _____ **Cell Phone:**_____

May we contact you at home? **YES / NO** May we contact you at work **YES / NO**

May we contact you on your cell phone? **YES / NO**

If there is a phone message system may we leave a message for you at any of the contact numbers you have provided? **YES / NO** Comment:_____

Can a message be left with our company name and what the call is in reference to? **YES / NO**

Is there anyone we can leave a message with? **YES / NO** ***(If yes, please list first and last names as well as contact numbers)***

_____ _____

_____ _____

_____ _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm, and change appointments only. **YES / NO (*If yes, please list first and last names as well as contact numbers)***

_____ _____

_____ _____

(Patient Signature) **(Date)**

Is there anyone you would like to designate as your personal representative that we may discuss your procedure, course of treatment and status? **YES / NO** ***(If yes, please list first and last name as well as contact numbers)***

_____ _____

_____ _____

(Patient Signature) **(Date)**

Michigan Outpatient Vascular Institute provided me with a copy of my rights as a patient under the HIPPA 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 Signature) **(Date)**

_____ _____

(Witness) **(Date)**