This is a request for confidential communications of my protected health information (PHI.) When doctor, nurse, or other members of your office want to contact me please use the following guidelines. I understand that you will do your best to adhere to the following requests.

Please check all that apply to this request:

___ Please do not phone me at home. Use the following alternative number to contact me: ______________________

___ Please do not phone me at work. Use the following alternative number to contact me: ___________________

___ Please do not contact me by email.

___ Other request (s) (describe in detail): ____

____

When contacting me by phone its ok to leave a message and discuss my health information with:

Name: _________________________________ Relationship: ____________________________

Name: _________________________________ Relationship: ____________________________

____ (Please initial): I understand that the physician/provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that is some emergency situations, my PHI may be released. I authorize my medications from the Pharmacy Data Base be released to this office.

Advanced Directive Planning

Do you have an Advanced Directive? ☐ Living will ☐ Power of Attorney ☐ DNR ☐ I do not have an Advanced Directive

Consent for Medical Treatment

I/We voluntarily consent to medical treatment and diagnostic procedures provided by this office and its associated physicians, clinicians, and other personnel. I/We am/are aware that the practice of medicine and surgery is not an exact science and I/We acknowledge that no guarantee has been made as to the result of treatments to this office.

Assignments of Benefits and Patient Responsibility

I certify that the information on these forms is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services, and all second opinion and pre-admission review requirements are ultimately my responsibility.

Signature of Patient (or patient's personal representative):
____

Relationship of representative to patient:
____

Date: ______________________________________