Health Insurance Portability and Accountability Act (HIPAA)
Privacy Compliance Patient Questionnaire

All patients have the right to have confidential care provided. All information, medical, or social (whether written, spoken, electronic or computer generated) is to be held in strict confidence. Please fill out this information in order for Taylor Family Practice to provide better service.

If anything is seriously abnormal, our office will notify you by telephone, letters are sent out regarding other tests. If you are not notified, please DO NOT assume everything is normal. Call our office if it has been over six weeks since your test and you are not notified.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis. Please list complete name and phone number:
   _____
   _____
2. Please list the family members or significant others (if any) whom we may inform about your medical condition ONLY IN EMERGENCY. Please list complete name and phone number
   _____
3. Please print the address of where you would like your billing statements and/or Correspondence from our office to be sent:
   _____
   _____
4. Please print the telephone number and Email address (if any) where you want to receive calls about your appointments, lab and x-ray results or other healthcare information:
   Phone Number: _____
   Email Address: _____
5. Can confidential messages (including appointment reminders) be left on your home answering machine or voicemail? Yes ☐ No ☐
6. If you DO NOT have voice mail, can a message asking you to call us about results or to confirm your appointment be left at your place of employment? Yes ☐ No ☐
7. Are you moving in 30 days, or changing home or work phone number? If so, please notify our office as soon as you have your new information in order for us to contact you with any test results or provide information below:
   New address and effective date:
   _____
   _____
   New phone number(s) and effective date: _____

_____ (Guardian if under 18 years old)
Patient Name (Printed)

AUTHORIZATION OF ELECRONIC COMMUNICATION:
I hereby authorize Taylor Family Practice to send and receive appointment reminders to me via electronic communication (i.e. Email, Text message, etc.).

AUTHORIZATION OF ELECRONIC COMMUNICATION:
I hereby authorize Advantages Pharmacy to send and receive electronic communication (i.e. Email, Text message, etc.) regarding, but not limited to, filling, refilling and authorizations of prescriptions.

Signature: _____ Date: _____