DIGESTIVE
DISEASE
CONSULTANTS

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
PRIVACY COMPLIANCE PATIENT QUESTIONNAIRE

All patients have the right to confidential care. All information, medical or social, whether written, spoken, electronic, or computer-generated, is to be held in strict confidence. Please complete this information in order for Dr. Nathan to provide better service.

1. Please list any family members or any other person, who we may inform about your general medical condition or your diagnosis. Please list their complete names and phone numbers.
   ____
   ____
   ____

2. Please list family members or other persons, if any, who we may inform about your medical condition. ONLY IN CASE OF EMERGENCY. Please list their complete names and phone numbers.
   ____
   ____
   ____

3. If you would prefer that billing statements and/ or correspondence from our office to be sent to an address other than your home, please provide that address below (otherwise, leave blank).
   ____
   ____
   ____

4. Should confidential messages (including appointment reminders) be left on your home answering machine or voicemail?
   ☐ Yes ☐ No

5. If you do not have voice mail at work, should messages asking you to call us about results or to confirm your appointments be left at your place of employment?
   ☐ Yes ☐ No

6. Please give a number that you can be reached for test results: ______________________________________

Patient Name (Print): ____ (guardian if under 18 years old)

Signature: ____________________________ Date: ________________