Name:_____

DOB:_____

PREFERRED TELEPHONE/MESSAGE & COMMUNICATION AUTHORIZATION

Mountain View Family Health Care is committed to ensuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To assist us in protecting your privacy, please complete the following information:

Preferred number to contact you: _____ Home Cell Work

May we leave a voicemail if no answer? Yes No

May we discuss information with someone other than you regarding your medical care (medication changes, laboratory results, billing issues, appointments, etc.)? If so, please list the name(s) in the space(s) below.

Billing Issues: Yes No Medical Issues: Yes No

Name:_____ Phone: _____ Relationship to patient:_____

Name:_____ Phone: _____ Relationship to patient:_____

Patient
Signature:_____Date:_____

PLEASE COMPLETE IF PATIENT IS A MINOR (Less than 18 years old):

Age of minor:_____ Name of person completing form:_____
Please Print Relationship

If Parent of Legal Guardian is unavailable to accompany minor to appointment, please list authorized caretaker(s):

Name:_____
Please Print

Name:_____
Please Print

If minor is able to attend appointment unaccompanied, I agree to be financially responsible:

Parent or Legal Guardian Signature:_____

Date:_____