Patient Registration & HIPPA Acknowledgement

Patient Name: _____ Birthdate: _____
Age: _____ Sex: _____ Marital Status: _____ SS#: _____
Patient Street Address: _____
Patient City, State, Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

- Please check here if you would like to opt out of email correspondence

How did you hear about us? Newsletter ___ Patient ___ Referral ___
Website ___ Other ___
Employed By: _____ Occupation: _____
Insurance Company: _____ Policy #: _____
Insurance Subscriber: _____ Subscriber DOB: _____

Emergency contact, relationship, phone #: _____
Name of primary care doctor: _____ Phone #: _____

I, _____, acknowledge that I have received a copy of My Path Medical Center's Notice of Privacy Practices (HIPPA).

Further, I give permission to the doctors and/or their authorized representatives at My Path Medical to communicate test results and other private medical information to me via the following: (Please circle yes or no for each of the following)

Yes No Secure voicemail/answering machine: _____
Yes No Secure Fax number: _____
Yes No Other: _____
Initial: _____

I authorize My Path Medical and its employees to discuss and transmit information regarding the aspects of my care with the individuals listed below:

(Please initial)

Appointments _____ Diagnoses_____ Orders _____ Treatment _____

Medications _____ Payment _____ Medical Records _____

Individuals:	**Relationship:**
_____	_____
_____	_____
_____	_____

I understand that I have the right to add or remove individuals from this list at any time, provided I inform My Path Medical of these changes in writing. Initial: _____

Please sign below to indicate that you have read and understand the privacy policy.

Patient Name (please print) **Patient of Legal Guardian's Signature** **Date**