Patient Registration & HIPAA Acknowledgement

Patient Name: ______________________________________ Birthdate: _______________
Age: _________ Sex: _____________ Marital Status: _____________
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 (HIPAA).

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**