Associates in Gastroenterology, S.C.

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Office Policies

Patient Name: D.O.B.:

I, _____acknowledge that I have been given the opportunity to review the Notice of Privacy Practices of *Associates in Gastroenterology, S.C*.

_____ Date:_____
Signature

Printed Name:_____ Relationship to Patient:_____

Communication

Associates in Gastroenterology, S.C. is concerned with your right to privacy. We want to ensure the secure and private communication of your protected health information. In order for us to communicate your private health and account information in a manner acceptable to you, we ask that you list your communication preferences for us (i.e. home phone, mobile phone, postal mail, etc.). **A detailed message could include information related to your personal health, treatment or payment for treatment including, but not limited to, appointments, test results, diagnosis, insurance coverage and payments.**

Preferred Method of Communication	OK to leave a detailed message (please circle)	
1. _____	Yes	NO
2. _____	Yes	NO
3. _____	Yes	NO

If you would like to authorize us to share your private health or account information (the same information that is underlined above) with anyone other than yourself, please list their name and their relationship to you below.

	NAME:	RELATIONSHIP:
1.	_____	_____
2.	_____	_____
3.	_____	_____

I have read and understand the above policies.

_____ Date:_____
Signature

Printed Name:_____ Relationship to Patient:_____