**Bellevue Family Practice, P.C.**

ANNUAL UPDATE

**HIPAA/Notice of Privacy Practices**

Patient Name (print): \_\_\_\_\_\_\_\_\_ Date of Birth:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the HIPAA/Notice of Privacy Practices for **Bellevue Family Practice.** I have been given the opportunity to ask any questions I may have regarding the Notice of Privacy Practices for Bellevue Family Practice.

**I wish to be contacted at the following numbers:**

**Home Phone:** ( ) -\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. **Cell Phone:**( ) -\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

€ Ok to leave detailed message € Ok to leave detailed message

€ Leave call back number only € Leave call back number only

**Business Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Business Phone**:(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

€ Ok to contact me at this number

€ Do not contact me at this number

Written Communication: (please circle one) YES NO

Email Communication: (please circle one) YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address**

**Bellevue Family Practice now offers a new patient portal.**

**Whom may we speak with regarding your health information:**

(this includes but is not limited to: information regarding lab results, refills, medical instructions, etc)

ONLY INITIAL ONE:

Initial here if you **DO NOT** want BFP to speak with anyone regarding your health information (except for as provided in the Bellevue Family Practice Notice of Privacy Policies.)

OR

Initial here if BFP **IS ALLOWED** to speak with anyone regarding your health information. (Please fill out box below)

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Phone Number |
|  |  |  |
|  |  |  |
|  |  |  |

I hereby consent that the above information is true and accurate.

|  |
| --- |
| **For Internal Use Only** |
| Updated in NextGen € |

\_\_\_\_   
Signature of Patient or Parent/Legal Guardian Date