NEW PATIENT

Bellevue Family Practice, P.C.

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
□ Leave call back number only

□ Ok to leave detailed message
□ 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.

_____ _____

Signature of Patient or Parent/Legal Guardian Date

For Internal Use Only
Updated in NextGen □