NORFOLK PLASTIC SURGERY, P.C.
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Patient Questionnaire and Receipt of Notice of Privacy Practices Written Acknowledgement Form

Patient: Date:

You may be contacted by the office to remind you of any appointments, healthcare treatment options, billing concerns, or other health services that may be of interest to you.

May we contact you at home? Yes No Phone: ______________________ OK to leave a message? Y / N
May we contact you at Work? Yes No Phone: ______________________ OK to leave a message? Y / N
May we contact you by cell? Yes No Phone: ______________________ OK to leave a message? Y / N

Comment: ____

Can a message be left with the doctor's name and what the call is in reference to? Y / N

Is there anyone we can leave a message with? Y / N (If yes, please list their full name and relationship to you below)

____ ______________________________
(Name) (Relationship)

____ ______________________________
(Name) (Relationship)

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. Y / N (If yes, please list their full name and relationship to you below)

____ ______________________________
(Name) (Relationship)

I, ___________________, have had a copy of the HIPPA notice of privacy practices made available to me.

____ ______________________________
Patient Signature Date

____ ______________________________
Witness Date