Neal Wieder, DC, DCBCN
Chiropractic Physician
1045 Primera Blvd., Ste. 1017
Telephone: 407-682-4454
Cell: 407-388-5825

Sheila L. Scott, AP, MSOM
Acupuncture Physician
Lake Mary, Florida 32746
Fax: 407-915-6853
Cell: 407-484-2183

PATIENT HIPAA QUESTIONNAIRE

1. Please list the family members, medical professionals, attorneys or other persons, if any, whom we may inform about your general medical condition and your diagnosis(es) (including treatment, payment and health care procedures or surgeries):

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2. Please list the family members, medical professionals, attorneys or significant others, if any, whom we may inform about your medical condition **IN THE EVENT OF AN EMERGENCY:**

Name ________________________________ **Phone** _________________________ **Fax:**___________________
Name ________________________________ **Phone** _________________________ **Fax:**___________________
Name ________________________________ **Phone** _________________________ **Fax:**___________________

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if ***other than your home.***

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4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL". YES** ______________ **NO** ________________

5. I authorize this office to transmit my health information by either facsimile or email: **YES**______ **NO**_______

6. Please print the telephone number you prefer to receive calls/texts about your appointments, lab, tests and x-ray results, or other health care information, **Cell**: ____________________ **Home:** _______________________

7. I authorize this office, it's physicians or employees to either text me, email me or phone & leave me confidential messages on my cell phone or home answering machine, voicemail or email address: ______________________ **YES** _______________ **NO**________________

   **** I AM FULLY AWARE THAT A CELL PHONE, THE INTERNET OR EMAIL IS NOT 100% SECURE AND PRIVATE.**

Email: ____**Fax:**______________________________

(Cell)_________________________ **(Home)**_____________________ **(Work)**______________________________

PATIENT NAME: __________________________________ _______________________________

PATIENT/GUARDIAN SIGNATURE: ____

DATE: ___________________________