Proliance Surgeons-Bellevue Ear Nose and Throat/Lake Washington Facial Plastics/Sound Hearing

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing this form you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

Signature: _____

Consent to leave Messages on voicemail

I,_____,give Bellevue ENT/Lake Washington Facial Plastic Surgery/Sound Hearing permission to:

Leave a message regarding my upcoming visit, account information, and/or test results on my voicemail (circle one)	Yes	No
Leave a message with someone who may answer the phone at my residence (circle one)	Yes	No
Leave a message at my place of employment (circle one)	Yes	No

Emergency contact information

Emergency contact: _____ Phone number _____ Relationship:___

Pharmacy Information:

Name of Pharmacy: _____

Phone number of Pharmacy: _____

Location/address of Pharmacy: _____

The federal government is requiring that we ask you these questions as part of the law governing Electronic Health Record:

What is your race? (circle one)

American Indian or Alaska Native
Asian
Native Hawaiian or Other pacific Islander
White/Caucasian
Multiracial
Other:_____
Decline to answer

What is your preferred language?(circle one)

American Sign language	Korean
Mandarin Chinese	Russian
Mandarin Cantonese	Somali
English	Spanish
Filipino	Vietnamese
French	Other:_____
Japanese	Decline to Answer

Do you consider yourself to be of Hispanic or Latino ethnicity?(circle one)

Yes No Decline to answer

Patient Signature: _____ Today's date: _____

Patient Name: _____ Date of birth: _____

If other than patient, Name: _____ Relationship to patient: _____