Keith E. Schulze, M.D., P.A.
281-980-6647

Receipt of Notice of Privacy Practices Written Acknowledgement Form and Contact Questionnaire

Patient Name (Printed): _____

You may be contacted by this office to remind you of appointments, treatment options, test results, or other health services that may be of interest to you.

May we contact you:

at home? ☐ Yes ☐ No _____ (Telephone Number) OK to leave voicemail? ☐Yes ☐No

at work? ☐ Yes ☐ No _____ (Telephone Number) OK to leave voicemail? ☐Yes ☐No

via cell phone? ☐ Yes ☐No _____ (Telephone Number) OK to leave voicemail? ☐Yes ☐No

Comment (*if any*): _____

_____

Can a message be left with our office name and what the call is in reference to? ☐Yes ☐No

Is there anyone we can leave a message with? ☐Yes ☐No (If yes, please list first and last names).

Name: _____ Phone:_____

Relationship: _____

Name: _____ Phone:_____

Relationship: _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments for you. ☐Yes ☐No

(If yes, please list first and last names).

Name: _____ Phone:_____

Fort Bend Skin Cancer Center has provided me with a copy of my rights as a patient under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been provided the opportunity to read and understand my rights, ask questions regarding my rights, and receive answers to my satisfaction.

_____ _____

Patient's Signature Date