SUBURBAN SURGICAL ASSOCIATES, LTD.
SUBURBAN METABOLIC INSTITUTE, LLC.

PATIENT PRIVACY PRACTICES

Patient Name:_____ **Birth Date:**_____

1. **My medical care may be discussed with my: □ Significant Other □ Parent □ Children**

   List Names that apply:_____

   _____

2. **Test results may be left on my answering machine/voicemail: □ Yes □ No**
3. **Appointment information may be left on answering machine/voicemail: □ Yes □ No**
4. **Billing information and requests can be discussed with designated person(s): □ Yes □ No**

5. **Medical Information may be emailed to me:** _____ **□ Yes □ No**
6. **Preferred form of communication: □ Home Phone □ Cell Phone**

I,_____ **have received the Notice of Privacy**
(Patient Signature)
Practices and the list of Office Policy and Procedures from SSA/SMI .

For personal representative of the patient: ***if patient is a minor or if the patient has a guardian to make their medical decisions.***

Print Name of Personal Representative:_____**Date:**_____

Relationship:_____

Signature of personal representative: _____