ADVANCED DERMATOLOGY LASER & COSMETIC SURGERY
1220 Avenue P Brooklyn, NY 11229
718-375-7546 (Tel) 718-376-6475 (Fax)

PATIENT NOTIFICATION RECORD OF CONFIDENTIALITY POLICY AND ADVANCE DIRECTIVES

PATIENT NAME_____

DOB_____

INSURANCE_____

THE PATIENT NAMED ABOVE OR THE PATIENT'S FAMILY OR REPRESENTATIVE HAS BEEN GIVEN THE FOLLOWING NOTICES AS REQUIRED BY STATE AND FEDERAL REGULATIONS:

Confidentiality policy effective April 14, 2003
as required by HIPPA of 1996
Yes○ NO○

ADVANCE DIRECTIVES PACKET
Yes○ NO○

Does patient have Advance Directives?
Yes○ NO◉

If YES specify:
Health Care proxy○ Living Will○ DNR○ Other○ _____

COPY OF ADVANCE DIRECTIVES PLACED IN PATIENT'S MEDICAL RECORD:
YES◉ NO○

INFORMATION COULD BE OBTAINED AND/OR PROVIDED AT THIS VISIT:
YES○ NO○

DOES PATIENT WISH ADDITIONAL INFORMATION:
YES○ NO○

PATIENT/ PATIENT'S REPRESENTATIVE REQUESTING ADDITIONAL INFORMATION AND REFERRED TO:
M.D.◉ R.N.○ Patient Representative○

_____ Apr 10, 2014
Patient's Signature Date

_____ Apr 10, 2014
Signature of Patient's Representative/ Relationship Date

_____ Apr 10, 2014
Witness/ Front Desk Representative Date

Reset all | Save PDF | Print PDF | Email PDF