Due to Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information must be filled out by each patient.

Date: _____

I authorize Dr. Makowski and Dr. Schaffer to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends your office visity and is in the exam room at the time of your evaluation and/or treatment, I give my permission to discuss freely my condition, treatment, or diagnosis with that person. **YES / NO**

HOME PHONE: _____MAY WE LEAVE A MESSAGE: **YES / NO**

WORK PHONE: _____MAY WE LEAVE A MESSAGE: **YES / NO**

CELL PHONE: _____MAY WE LEAVE A MESSAGE: **YES / NO**

May we leave a message at one of the listed numbers above about appointments with this office? **YES / NO**

May we call you name out loud in the lobby? **YES / NO**

With whom may we discuss or release information about your care, treatment, or diagnosis?

_____Relationship_____

_____Relationship_____

With whom my we **NOT** discuss or release information about your care, treatment or diagnosis?

_____Relationship_____

Signature:_____

(signature is valid one year from date shown above)

Printed Name: _____