Southeastern Center for
Fertility and Reproductive Surgery

Patient Privacy Questionnaire

Patient's Name _____ CELL (____) ____-_____

1. May we leave confidential messages with anyone answering the telephone at your home? Yes ___ No ___
   If yes, with whom?_____

2. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home answering machine or voicemail? Yes ___ No ___

3. May we leave confidential messages with anyone answering the telephone regarding appointments, lab results, or other healthcare information at numbers other than your home number? Yes ___ No ___
   If yes, with whom? _____Number (____) ____-_____

4. If we are unable to reach you by any of the above options, may we leave confidential messages at your place of employment? Yes ___ No ___

   If we are unable to reach you by any other means, we will send information through the U.S. Postal service to your home address.

_____ _____
Signature of patient (or guardian if under age 18) Date

I have received a copy of the Southeastern Center for Fertility and Reproductive Surgery (SCFRS) Notice of Privacy Practices. I understand that this Notice describes how my health information may be used or disclosed by SCFRS. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (865) 777-0088 or requesting one at the office.

_____ _____
Signature of patient (or guardian if under age 18) Date