Women's Healthcare of Morristown
Covenant HEALTH

DISCLOSURE CONSENT

I can ask for and receive a copy of the Notice of Privacy Practices for this office upon request.

We are committed to providing an office environment that is professional, caring, and respectful of your time and privacy. The following agreement outlines communication information and office policies that are important in providing you with the best care.

I understand that it may/will be necessary to contact me with test results, billing questions, information about referrals to other offices, or to obtain medical information which may be needed to provide appropriate care.

What telephone number do you want us to call?

May we leave messages on *your* voice mail or answering machine?

YES ☐ NO ☐ N/A ☐

Is there anyone other than yourself we can speak to or leave messages with?

YES ☐ NO ☐ **If *YES* :**

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

Electronic (EMAIL) Communication: _____@

EMAIL : YES ☐ NO ☐ PORTAL: YES ☐ OPT OUT ☐

I understand FSWS & FSPNC may need to disclose my protected healthcare and personal information to another entity (referring doctors, primary-care doctors, pharmacies, making referrals, your insurance company) and I consent to disclosure for these permitted uses, by fax or telephone.

Referring Doctor: _____ **Phone:** _____

Primary Care Doctor: _____ **Phone:** _____

PATIENT & GUEST AGREEMENT:

NO FOOD OR DRINKS are to be brought into our waiting rooms or exam rooms. Please eat or drink all food items before entering our suite.

Due to **LIMITED SPACE** in our office we can only allow **2 people**, including children, back with you during your appointment. If you are having an ultrasound, we allow 2 people to switch out half way through the ultrasound so other family members may be included.

CELL PHONES: Please TURN OFF/SILENCE all cell phones while in our office. NO PHOTOGRAPHS are to be taken out of respect for the privacy of other patients.

I have read the agreements above and understand. I can ask for and receive a copy of this notice for my records.

_____
Patient Signature Date

_____
Signature of Guardian if Patient is a Minor Date Patient ID _____