BREAST CARE OF WESTERN NEW YORK

Patient Name _____ Date of Birth _____

Patient Communications

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone _____**
- (☐) **O.K. to leave message with detailed information**
- (☐) **Leave message with call-back number only**

☐ **Work Telephone _____**
- (☐) **O.K. to leave message with detailed information**
- (☐) **Leave message with call-back number only**

☐ **Cellular Telephone _____**
- (☐) **O.K. to leave message with detailed information**
- (☐) **Leave message with call-back number only**

☐ **Written Communication**
- (☐) **O.K. to mail to my home address**
- (☐) **O.K. to mail to my work/office address**

_____

- (☐) **O.K. to fax to this number**

_____

☐ **In Case of Emergency, contact:**

Name_____

Relationship_____

_____

Telephone Number(s)

_____

Notice of Privacy Practices

I acknowledge that I have received the *Notice of Privacy Practices* and I have been provided an opportunity to review it.

Notice of Office-Patient Policies

I acknowledge that I have received a written copy of the Office-Patient Policies and that I understand these policies.

Signature____

Date___________________________