



## CONFIDENTIALITY QUESTIONNAIRE

Please list below family/friend, if any, whom we may inform about your care, treatment, medical condition, and payment. We ask that **no more than two (2) people** be designated as the **contact people**. The names and telephone numbers of your contact people will be listed below and this sheet will become a part of your medical record. Your contact people may contact Orthopaedic Associates of Southern Delaware, P.A., at (302) 644-3311 during business hours (8:30 a.m. - 4 p.m.) and the call will be returned as soon as possible. It is important for our staff to maintain your confidentiality; therefore, we will not give detailed information about you unless you have requested us to do so and then **only** to your contact individuals named below. **All other persons who request information about you will be referred to your contact people.** This system has been designated so that you can participate in your care and determine your own spokesperson. We are aware that your family and friends are concerned about your welfare and progress. **Please inform them to call your contact people for information about you.**

Please print below the address of where you would like your billing statements (For example, if there is any balance remaining after your insurance company has paid, any deductibles not met, co-pays not paid, or if you have no insurance) and/or other correspondence:

Billing Statement address:  Mail to my home address listed on file.

Other address: \_\_\_\_\_  
\_\_\_\_\_

Correspondence address:  Mail to my home address listed on file.

Other address: \_\_\_\_\_  
\_\_\_\_\_

May we contact you at work to remind you of appointments, lab results, etc.?  Yes  No

I have read and understand this policy. I hereby designate the following people to be the contact individuals for communication while I am under the care of Orthopaedic Associates of Southern Delaware, P.A. This right of information ends when I am discharged from service and I can change these contact people at any time.

**Contact Person #1:** \_\_\_\_\_ Password: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_  
(home) (work)

**Contact Person #2:** \_\_\_\_\_ Password: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_  
(home) (work)

Print Patient Name: \_\_\_\_\_ Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Guardian)