Ami Laws, M.D.
Patient Registration

Patient Name: _____ Date of Birth: _____

Gender (check one): ( ) Female ( ) Male Marital Status: ( ) Single ( ) Married SS#: _____

Address: _____City: _____ State: ____ Zip Code: _____

Phone(s): Home: _____ Work: _____ Cell: _____

E-mail (private): _____ Fax (secure): _____

Emergency Contact: _____ Phone: _____

Address: _____

Preferred Pharmacy: _____ Phone: _____

Primary Insurance: _____ ID#: _____ Group: _____

Subscriber (if other than self): _____ Date of Birth: _____

Secondary Insurance: _____ ID#: _____ Group#: _____

Subscriber (if other than self): _____ Date of Birth: _____

Consent use and/or disclosure of Information

I hereby give consent to Ami Laws, M.D. to use and disclose protected health information for the purpose of treatment, payment and healthcare operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request to: Ami Law, M.D., and 900 Welch Road, Suite 103, Palo Alto, CA 94304.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment o health care operations. We are not required to grant your request but if we do, the restriction is binding to us.

You may revoke this consent at any time. Your revocations must be in writing, signed by you or on your behalf, and delivered to the address above. You may deliver your revocations by any means you choose, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Email and Facsimile Consent Statement

I authorize my physician Ami Laws, M.D. and staff to communicate with me via email or facsimile about routine matters such as appointments, follow-up inquiries, prescriptions, laboratory and x-ray results, billings issues, and all other issues relating to my health. __ Yes __ No

I am at least 18 years of age. __Yes __ No

Print Full Name of Representative: _____ Describe your authority: _____

Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Relationship to Patient: _____

Print Full Name of Representative: _____ Describe your authority: _____