Brad Amos M.D. PhD, PC
9102 Babcock Blvd Suite 206
Pittsburgh, PA 15237

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Dr. Brad Amos not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

If you anticipate that you will need or want your medical information to be provided to family members friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please mark the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: ______________________________ ______Yes ______No

Parent: ______________________________ ______Yes ______No

Other: ______________________________ ______Yes ______No

______________________________ ______Yes ______No

______________________________ ______Yes ______No

Print name:____

Patient or (parent/guardian) Signature:____

Date:______________________________

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:______________________________________

FINANCIAL POLICY

I have recieved a copy of the Financial Policy . I understand the terms and conditions outlined herin as confirmed by my signature below

X____

FOR OFFICE USE
Changes to above authorized by patient over the phone:
Change Date

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