INTEGRATIVE HORMONE
Specialists

7505 New LaGrange Road
Suite102
Louisville, KY 40222

(502)412-3232
Fax (502)412-3233

DATE____________________

LAST NAME_____________________________FIRST______________________________MI_____________

SOCIAL SECURITY #___________________________________

DATE OF BIRTH :_________________

ADDRESS____

PHONE NUMBERS
HOME ____________________________
WORK ____________________ EXT____
CELL _____________________________

ZIP CODE______________________CITY____STATE_________

EMAIL ADDRESS: ____

EMERGENCY CONTACT:
____PHONE NUMBER___________________________________

PRIMARY CARE PHYSICIAN__________________WHO REFERRED YOU?____________________________

Health Information Privacy Protection Act

THESE QUESTIONS ARE BEING ASKED TO FULFILL OUR COMMITMENT TO PROTECT YOUR PRIVACY

Is there anyone other than you that we can discuss your medical information? Yes No Who? ___________________

May we contact you at home, by cell phone or by email to confirm appointments, give test results, or billing information? Yes No

May we leave a message at your home, cell phone or by email to confirm appointment, test results or billing information? Yes No

May we contact you at work to confirm appointments, test results, and/or billing information? Yes No

If you are unavailable at work may we leave a voice mail message or with the person answering the phone? Yes No

May we give your social security number to a pharmacy for a controlled substance (i.e testosterone)? Yes No

IF WE HAVE PERMISSION TO LEAVE A MESSAGE AT HOME OR WORK WE WILL BE IDENTIFYING OURSELVES AS WELL AS WHAT OFFICE WE ARE CALLING FROM.

May we leave a message at work if you are unavailable? Yes No

Upon request may we fax or email you information concerning your health or billing information? Yes No

IF YOU DO NOT WANT US TO CONTACT YOU AT HOME OR WORK HOW MAY WE CONTACT YOU?

PLEASE LEAVE PHONE NUMBER AND/OR ADDRESS ____

_________________________________ _________________________________ DATE _________
Signature if patient/guardian/parent/P.O.A Please print name of previous signature

I acknowledge the document titled: Notice of Privacy Practices

Sign Name______________________________Print Name________________________________Date_______