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_____