The information provided below is never shared without the written permission of the patient or guardian.

Patient Name: (Last)_____(First)_____(M.I.)_____

Date of Birth: _____ □ Male □ Female S.S.# _____

Phone: _____ Alt. Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: □ Single □ Married, Spouse_____ □ Divorced □ Widowed □ Separated

Place of employment:_____Phone:_____

Contact in case of emergency: _____ Phone: _____

Race: □White □Black or African American □American Indian □Asian □Native Hawaiin or Pacific Islander or

□ Other_____ Ethnicity: □ Hispanic/Latino □ Other_____

List any medical conditions you have □ None _____

List any major surgeries or hospitalizations you have had □ None _____

_____

List any significant family medical history that you know of (cancer, heart disease, etc.)_____

_____

List Medications and dosage you are currently taking □ None _____

_____

_____

List Over The Counter Products (i.e. Medicine and/or Vitamins) and dosage you are currently taking □ None _____

_____

_____

Please list any drug or food allergies you have □ None _____

Do you smoke? □ Yes □No If yes, How Much? _____ for how long?_____

Have you ever smoked? □Yes □ No If yes, for how long?_____ When did you quit?_____

Do you drink alcohol? □Yes □ No If yes, How Much?_____ Daily Weekly Socially (Please Circle)

Do you drink caffeine? □Yes □ No If yes, How Much?_____ Daily Weekly Socially (Please Circle)

What type of caffeine do you drink? Coffee Tea Soda Energy Drinks (Please Circle)

IF UNDER 18, PLEASE GIVE PARENT'S OR LEGAL GUARDIAN'S NAME AND ADDRESS:

Name: _____ Phone: _____

Address: _____City: _____

State: ____ Zip: _____ Relationship to patient:_____

PATIENT RESPONSIBILITIES

1. The patient is responsible for providing physicians and staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the general health of the patient.
2. The patient has the responsibility for reporting unexpected changes in his/her condition to members of his/her healthcare team.
3. The patient and his/her family members are responsible for being considerate and not disruptive of the needs of the patients, physician and medical staff.
4. The patient is responsible for providing Kirchner Clinic with current information on his/her address and/or phone number.
5. The patient is responsible for providing Kirchner Clinic with current Medicare insurance information.

OFFICE FINANCIAL POLICY

Payment in full is due on the day the services are rendered.
We gladly accept cash, check, Visa, MasterCard and Discover. Additional financial arrangements are available through Care Credit. **Please Initial_____**

If you have insurance coverage; you will be provided with a receipt called a Super Bill. This Super Bill will have the necessary codes for **YOU TO SUBMIT TO YOUR INSURANCE COMPANY YOURSELF!** ***We still expect payment in full the day the service is rendered.***

If you have Medicare coverage; Kirchner Clinic will submit your Medicare claims so you must provide us with a current copy of your Medicare card and supplement card.
We still expect payment in full the day the service is rendered.

Appointments:
We consider your time to be valuable and will make every effort to see you at your appointed time. Due to unexpected emergencies, we occasionally do run late. We appreciate your understanding in this matter.

Because your appointment time is reserved for you, if there is an issue where you will be unable to attend your appointment we at the Kirchner Clinic would appreciate notification as soon as possible. Preferably a 24-hour notice. We have a patient waiting list for the doctors and the appointment time could be filled. **Please Initial_____**

Returned Check:
In the event that your check is returned to us from the bank, you will be charged $35.00. You will be required to pay the amount of the original check plus the returned check fee within (5) days by cashier's check, money order or cash. Failure to do so will result in your account being turned over to our attorneys.

Signature below indicates that I have read, understand and accept the policies as outlined above.

Date

_____ _____
Signature Date

PURPOSE: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Do we have your permission to mention to others you were in the office? (According to the HIPPAA guidelines, we cannot acknowledge you are in the building. May we tell someone who calls for you that you are here, for purposes of messages, picking you up, etc.?)

(circle one) YES NO

Do we have permission to discuss your treatment or financial arrangements with your spouse?

(circle one) YES NO

Do we have permission to discuss your treatment with your direct family?

(circle one) YES NO

Do we have permission to discuss financial arrangements with your family?

(circle one) YES NO

Do we have permission to call you with an appointment reminder phone call?

(circle one) YES NO

I, _____, have received a copy of the Confidentiality Notice,
(Please print your name here)
and it has been explained to me.

_____ _____
Signature **Date**

_____ _____
Parent/Guardian Signature (if necessary) **Date**