## 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	$\square$ Female	S.S.#	
Phone: Alt. Phone: _		_ Email:		
Address:				
City:		State:	Zip:	
Marital Status: ☐ Single ☐ Married, Spous	e		□ Divorced	☐ Widowed ☐ Separate
Place of employment:			Phone:	
Contact in case of emergency:			Phone:	
<b>Race:</b> □ <b>White</b> □Black or African Ameri	can □American	ndian 🗆 Asian 🛭	□Native Hawaiin or I	Pacific Islander or
OtherEthi	nicity: 🗆 Hispani	c/Latino 🗆 Other_		
List any medical conditions you have $\square$ N				
List any major surgeries or hospitalization	s you have had □	None		
List Medications and dosage you are curre	ently taking   No	ne		
List Over The Counter Products (i.e. Medi	icine and/or Vitar	mins) and dosage	you are currently tal	king □ None
List Over The Counter Products (i.e. Medi	icine and/or Vitar	mins) and dosage	you are currently tal	king □ None
List Over The Counter Products (i.e. Median Please list any drug or food allergies you have Do you smoke?   Yes  No If yes, How	nave  None	mins) and dosage	you are currently tal	king   None
List Over The Counter Products (i.e. Median Please list any drug or food allergies you have you smoke?   Yes No If yes, How Have you ever smoked?  Yes No If	icine and/or Vitar  nave  None   w Much?   yes, for how long	mins) and dosage	you are currently tal	king   None
List Over The Counter Products (i.e. Median Please list any drug or food allergies you have you smoke?   Yes No If yes Do you drink alcohol?  Yes No If yes	nave  None  we Much?  yes, for how long  s, How Much?	nins) and dosage  for hog?  Dail	you are currently tal ow long? When did you quit'y Weekly Sociall	xing □ None
List Medications and dosage you are curred.  List Over The Counter Products (i.e. Medications)  Please list any drug or food allergies you be the product of	nave  None w Much? yes, for how longs, How Much?	nins) and dosage  for hog?  Daily	you are currently tal ow long? When did you quit' y Weekly Socially Weekly Socially	xing □ None
List Over The Counter Products (i.e. Median Please list any drug or food allergies you have you ever smoked? □Yes □No If yes, How Do you drink alcohol? □Yes □ No If yes Do you drink caffeine? □Yes □ No If yes What type of caffeine do you drink? Con	nave  None  we None  we have long  yes, for how long  s, How Much?  have long  s, How Much?  have long  so how long  so ho	nins) and dosage  for hog?  Daily  Energy Drinks	you are currently tal ow long? When did you quit'ry Weekly Socially Weekly Socially (Please Circle)	xing □ None
List Over The Counter Products (i.e. Median Please list any drug or food allergies you have you ever smoked? □Yes □No If yes Do you drink alcohol? □Yes □ No If yes Do you drink caffeine? □Yes □ No If yes	nave   None   w Much? yes, for how long s, How Much? s, How Much? ffee Tea Soda	for hog? Daily Energy Drinks	when did you quit's Weekly Socially (Please Circle)	xing □ None

## 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 and/or phone number.	with current information on his/her address
5. The patient is responsible for providing Kirchner Clinic	with current Medicare insurance information.
OFFICE FINANCIAL  Payment in full is due on the day the services are render We gladly accept cash, check, Visa, MasterCard and Disco available through Care Credit. Please Initial	red.
If you have insurance coverage; you will be provided with Bill will have the necessary codes for YOU TO SUBMIT YOURSELF! We still expect payment in full the day the	TO YOUR INSURANCE COMPANY
If you have Medicare coverage; Kirchner Clinic will subsprovide us with a current copy of your Medicare card and so We still expect payment in full the day the service is rendered.	supplement card.
Appointments: We consider your time to be valuable and will make every to unexpected emergencies, we occasionally do run late. We matter.	• • • • • • • • • • • • • • • • • • • •
Because your appointment time is reserved for you, if there attend your appointment we at the Kirchner Clinic would a Preferably a 24-hour notice. We have a patient waiting list could be filled.  Please Initial	ppreciate notification as soon as possible.
Returned Check: In the event that your check is returned to us from the bank required to pay the amount of the original check plus the recheck, money order or cash. Failure to do so will result in attorneys.	eturned check fee within (5) days by cashier's
Signature below indicates that I have read, understand and	accept the policies as outlined above.
	Dat
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 \_\_, 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**