



Integrative Hormone Specialists
HEALTH ▾ WELLNESS ▾ BALANCE

7505 New Lagrange Road
Suite 102
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 _____

Signature if patient/guardian/parent/P.O.A

Please print name of previous signature

DATE _____

I acknowledge the document titled: Notice of Privacy Practices

Sign Name _____ Print Name _____ Date _____