PATIENT INTAKE FORM

General Information:

Name: Today's Date:

Patient's date of birth:

Address: City: State: Zip:

Cell phone: Home phone:

Work phone: Email:

Reason for Today's Visit:

List All Current Medical Problems and Health Concerns:

List All Medications and Supplements:

HIPPA Acknowledgement and Consent Form

Purpose of Consent: I understand that I have certain rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. The notice describes how we may use and disclose your protected health information and other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting: **208-263-1408 Sandpoint Super Drug Clinical Services 604 North 5th Ave Sandpoint, Idaho 83864.**

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the above contact person. Revocation of this consent will not affect any action we took in reliance of this consent prior to receiving your revocation.

Signature: I have had the opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Signature: Date: