FORM-5: Acknowledgement of HIPAA Receipt

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Essentially the HIPAA guidelines state that your private health care information will not be shared with anyone without your consent. A full copy of the HIPAA guidelines is being made available to you for your review.

By signing this document, I acknowledge that I was offered a copy of the notice of privacy practices (HIPAA) and understand its content.

I hereby give my consent for Huber Personalized Medicine and any appropriate affiliates to release my protected health information to the following individuals or family members:

_____Self only

_____Relationship to Patient_____

_____Relationship to Patient_____

Primary Care Physician: _____

Other Physician: _____

Print Name: _____

Signature: _____

Date: _____

Credit Card Policy

Credit Card Policy: Our office policy is to keep your credit card on file in a secured location and will not be used without notifying you. This is intended to make it more convenient for you to make any charges you desire but also provides us access to billing for any missed appointments with inadequate notice, returned checks, phone appointments, and any supplement orders.

We will never bill your credit card without your approval. We will always forward an invoice for any charges made. All charges are open for discussion.

- Credit Card #: _____
- CVV#: _____ Expiration Date: _____
- Patient Signature: _____

Patient Intake Forms – Clarification of responsibility of both parties

The forms mentioned below can be found on our website, www.huberpm.com or in our office waiting room

FORM-1: Patient Waiver

FORM-2: Financial Responsibility Statement

FORM-3: Patient Handbook

FORM-4: Medicare Private Contract

FORM-5 Acknowledgement of HIPAA Receipt

Please fill this form out to include anyone you grant permission to receive your personal health information such as family members or other physicians. **SEPARATE SIGNED PAGE**

FORM-8 Credit Card form

I have read and understand these documents entirely and I have been given the opportunity to receive a verbal explanation from the attending consultants and they have satisfactorily answered all my questions and or doubts.

I understand and agree to the information contained here, on this date: _____

Client's Name: (PRINT) _____

Client/Responsible Party Signature:

_____

Client Parent or Guardian Signature:

_____

Updated Questionnaire

Please Print

Date:	How did you hear about our practice? Facebook, Radio Ad, Google Ad, Personal Referral by:		
Name:			
Home Address:	City:	State:	ZIP:
E-Mail Address:			
Home Phone:	Cell:	Work:	
Sex:	Age:	Birth Date:	
Height:	Weight:	Desired Weight:	
Marital Status: Married Divorced Widow	Number of children & ages:		
Pharmacy:	Phone:	Fax:	
Social History	Occupation:	Employer:	
Do you smoke:	How much:	Quit:	
Alcohol consumption per week & type:			
Surgical History	Please list all surgeries ***since last visit***:		
Medical History	Please list any additional diagnosis ***since last visit***:		
Primary reason you came for evaluation			
Allergies: Medications			
Allergies: Food			
Allergies: Environmental			

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com

List any NEW Supplements & Vitamins since last visit	Dose	Frequency	Reason Why
List any NEW Medications (prescriptions) since last visit	Dose	Frequency	Reason why

Nutritional Assessment
Are you happy with your present weight? Wish to gain or lose weight?
What is your typical day's food and beverage intake? List food and beverage serving size.
Breakfast:
Lunch:
Dinner:
Snacks:
Soft drink consumption, type and amount: