



Steven L. Kaufman, Md, PhD, Facs  
 1136 E. Stuart Street, Suite 4102, Fort Collins, CO 80525  
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Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Preferred Language \_\_\_\_\_

Drivers License Number \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**INSURANCE INFORMATION:** (Please present your card at check-in.)

Name of Insurance Carrier \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referral Source \_\_\_\_\_

**LIFETIME AUTHORIZATION:** I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF FOR SERVICES RENDERED TO ME. I AUTHORIZE STEVEN L. KAUFMAN MD TO RELEASE INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND OBTAIN PRE-DETERMINATION.

**ASSIGNMENT OF BENEFITS:** I HEREBY ASSIGN STEVEN L. KAUFMAN MD., PhD., PC ANY INSURANCE OR THIRD PARTY BENEFITS AVAILABLE FOR HEALTH CARE SERVICES PROVIDED TO ME. I AGREE TO FORWARD ALL HEALTH INSURANCE OR THIRD PARTY PAYMENTS THAT I RECEIVE FOR SERVICES RENDERED IMMEDIATELY UPON RECEIPT.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



Steven L. Kaufman, MD, PhD, FACS  
 1136 E. Stuart Street, Suite 4102, Fort Collins, CO 80525  
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**CONFIDENTIAL HEALTH HISTORY**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Referring Doctor: \_\_\_\_\_

Please check all that apply:

**Internet Site**

- Internet site
- Total Vein Care website
- MD Connect
- Best Vein Care
- Google Search

**Phone Book**

- Fort Collins
- Loveland
- Greeley
- Longmont
- Cheyenne
- Laramie
- Other \_\_\_\_\_

**Newspaper**

- Coloradoan:
- Advertisement
  - Mind & Body Supplement

**Other**

- Free vein screening
- Friend/Patient (Name) \_\_\_\_\_
- Health Fair
- Magazine
- Radio

***Doctor's Notes:***

## VEIN HEALTH HISTORY

### CURRENT SYMPTOMS:

- |   |   |   |                    |            |
|---|---|---|--------------------|------------|
| <input type="checkbox"/> Heaviness/fatigue  | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | How long _____  | R or L worse _____ | Same _____ |
| <input type="checkbox"/> Pain/Aching        | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | How long _____  | R or L worse _____ | Same _____ |
| Severity of Pain                            | <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe   | # on a scale of 1 to 10 (10 being the worst) _____  |                    |            |
| Quality of Pain                             | <input type="checkbox"/> Achy <input type="checkbox"/> Crampy <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing |   |                    |            |
| <input type="checkbox"/> Spider Veins       | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | How long _____  | R or L worse _____ | Same _____ |
| <input type="checkbox"/> Varicose Veins     | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | How long _____  | R or L worse _____ | Same _____ |
| <input type="checkbox"/> Swelling/edema     | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | How long _____  | R or L worse _____ | Same _____ |
| Severity of edema                           | <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe   | R or L worse _____ Same _____   |                    |            |
| <input type="checkbox"/> Restless legs      | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |                    |            |
| <input type="checkbox"/> Itching            | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | How long _____  | R or L worse _____ | Same _____ |
| <input type="checkbox"/> Burning            | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | How long _____  | R or L worse _____ | Same _____ |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both   | How long _____  | R or L worse _____ | Same _____ |

### Leg ulcers:

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Active   | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | How long have ulcer(s) been open? _____     |  |  |
| <input type="checkbox"/> Healed   | <input type="checkbox"/> R <input type="checkbox"/> L                               | How long did it take to heal? _____         | What did you do to help it heal? _____                                       |  |
| <input type="checkbox"/> Bleeding from veins                                    | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | # of episodes _____                         |  |  |
|   |   | How long since last bleeding episode? _____ | Require transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| <input type="checkbox"/> Phlebitis  | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | How long ago _____                          | # of episodes _____  |  |
| <input type="checkbox"/> DVT  | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | How long ago _____                          | # of episodes _____  |  |
| <input type="checkbox"/> Pulmonary Embolus                                      |   | How long ago _____                          | Number of Episodes _____   |  |
| <input type="checkbox"/> Have you had a work-up for clotting problems?          | <input type="checkbox"/> Yes <input type="checkbox"/> No                            |   |  |  |
| <input type="checkbox"/> Prominent labial/vulvar veins                          | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | How long _____                              |  |  |
| <input type="checkbox"/> Prominent abdominal veins                              | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | How long _____                              |  |  |
| <input type="checkbox"/> Pelvic pain w/ prolonged sitting or sexual intercourse | <input type="checkbox"/> Yes <input type="checkbox"/> No                            |   |  |  |
| <input type="checkbox"/> Trauma to legs   | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | How long _____                              |  |  |

### Symptoms are worsened by:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Prolonged Standing | <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> After Exercise |
| <input type="checkbox"/> Heat               | <input type="checkbox"/> Premenstrual      | <input type="checkbox"/> Pregnancy      |
| <input type="checkbox"/> Walking/Exercise   | <input type="checkbox"/> During Exercise   |   |

### Symptoms interfere with my daily living:

- |   |  |                                |
|---|--|--------------------------------|
| <input type="checkbox"/> Work             | <input type="checkbox"/> Air travel    | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Leisure Activity | <input type="checkbox"/> Long car ride |                                |
| <input type="checkbox"/> Routine Activity | <input type="checkbox"/> Childcare     |                                |

### Conservative measures attempted to control symptoms:

- |  |  |
|--|--|
| <input type="checkbox"/> Leg elevation | <input type="checkbox"/> Avoidance of prolonged sitting or standing                            |
| <input type="checkbox"/> Exercise      | <input type="checkbox"/> Therapeutic compression stockings <input type="checkbox"/> Cold soaks |
| <input type="checkbox"/> Weight loss   | <input type="checkbox"/> Warm soaks  |

### **\*\*\*\* Compression Stocking Use**

First Used \_\_\_\_\_ # of years used \_\_\_\_\_ # of months used \_\_\_\_\_  Use currently  
Months used continuously in past year \_\_\_\_\_  
Compression Strength  15-20 mm  20-30 mm  30-40mm

**\*\*\*\* At least three months recent continuous stocking use is required for ablation preauthorization for most insurances.**

**I exercise:**

- Daily Times per week \_\_\_\_\_
- Weekly  No regular exercise

**I have attempted weight reduction:**

- Yes  No  Not an issue

**I have achieved relief of symptoms with:**

- Leg elevation  Weight loss  Therapeutic compression stockings  Warm soaks
- Exercise  Avoidance or prolonged sitting or standing  Cold soaks

**Prior Vein Treatments: If so, when? \_\_\_\_\_**

- Injection sclerotherapy  Ultrasound guided sclerotherapy  Laser ablation
- High ligation / stripping  Radiofrequency closure
- Phlebectomy  Laser/Radiofrequency surface treatment of spider veins

**Lymphedema History:**

- Age of onset \_\_\_\_\_
- Onset after  Diagnosis of cancer  Radiation therapy
- Surgery  Trauma
- Family history of lymphedema  Yes  No
- Tropical travel/filaria (parasite)  Yes  No
- Leg infections  Yes  No
- Elevation of leg(s)  Helps edema  Doesn't help edema

**MEDICAL HISTORY**

- |   |                            |  |                            |
|---|----------------------------|--|----------------------------|
| <input type="checkbox"/> Anemia                   | Year or # of yrs ago _____ | <input type="checkbox"/> Hypertension                  | Year or # of yrs ago _____ |
| <input type="checkbox"/> Angina                   | Year or # of yrs ago _____ | <input type="checkbox"/> Irritable bowel syndrome      | Year or # of yrs ago _____ |
| <input type="checkbox"/> Arthritis                | Year or # of yrs ago _____ | <input type="checkbox"/> Kidney Disease                | Year or # of yrs ago _____ |
| <input type="checkbox"/> Asthma                   | Year or # of yrs ago _____ | <input type="checkbox"/> Liver Disease                 | Year or # of yrs ago _____ |
| <input type="checkbox"/> Atherosclerosis          | Year or # of yrs ago _____ | <input type="checkbox"/> Lumbar spine disease          | Year or # of yrs ago _____ |
| <input type="checkbox"/> Bleeding/Blood disorders | Year or # of yrs ago _____ | <input type="checkbox"/> Lupus                         | Year or # of yrs ago _____ |
| <input type="checkbox"/> Bronchitis/Emphysema     | Year or # of yrs ago _____ | <input type="checkbox"/> Migraine headaches            | Year or # of yrs ago _____ |
| <input type="checkbox"/> Cancer of _____          | Year or # of yrs ago _____ | <input type="checkbox"/> Migraine headaches w/aura     | Year or # of yrs ago _____ |
| <input type="checkbox"/> Crohn's Disease          | Year or # of yrs ago _____ | <input type="checkbox"/> Mitral valve prolapse         | Year or # of yrs ago _____ |
| <input type="checkbox"/> Depression               | Year or # of yrs ago _____ | <input type="checkbox"/> Osteoporosis                  | Year or # of yrs ago _____ |
| <input type="checkbox"/> Diabetes                 | Year or # of yrs ago _____ | <input type="checkbox"/> Pace Maker                    | Year or # of yrs ago _____ |
| <input type="checkbox"/> Diverticulosis           | Year or # of yrs ago _____ | <input type="checkbox"/> Patent Foramen Ovale          | Year or # of yrs ago _____ |
| <input type="checkbox"/> GERD/reflux              | Year or # of yrs ago _____ | <input type="checkbox"/> Peptic Ulcer Disease          | Year or # of yrs ago _____ |
| <input type="checkbox"/> Heart disease            | Year or # of yrs ago _____ | <input type="checkbox"/> Pulmonary embolus             | Year or # of yrs ago _____ |
| <input type="checkbox"/> Heart murmur             | Year or # of yrs ago _____ | <input type="checkbox"/> Stroke or TIA                 | Year or # of yrs ago _____ |
| <input type="checkbox"/> Hepatitis                | Year or # of yrs ago _____ | <input type="checkbox"/> Thyroid disease               | Year or # of yrs ago _____ |
| <input type="checkbox"/> High Cholesterol         | Year or # of yrs ago _____ | <input type="checkbox"/> Trauma to leg(s)              | Year or # of yrs ago _____ |
| <input type="checkbox"/> HIV                      | Year or # of yrs ago _____ | <input type="checkbox"/> Ulcerative colitis            | Year or # of yrs ago _____ |
| <input type="checkbox"/> Hormone problem          | Year or # of yrs ago _____ | <input type="checkbox"/> Other medical problems: _____ |                            |

**PAST SURGERIES:**

- |  |                            |   |                            |
|--|----------------------------|---|----------------------------|
| <input type="checkbox"/> Appendectomy  | Year or # of yrs ago _____ | <input type="checkbox"/> Hysterectomy   | Year or # of yrs ago _____ |
| <input type="checkbox"/> Breast surgery-R <input type="checkbox"/> L <input type="checkbox"/>  | Year or # of yrs ago _____ | <input type="checkbox"/> Knee replacement-R <input type="checkbox"/> L <input type="checkbox"/> | Year or # of yrs ago _____ |
| <input type="checkbox"/> C-section   | Year or # of yrs ago _____ | <input type="checkbox"/> Lung resection- R <input type="checkbox"/> L <input type="checkbox"/>  | Year or # of yrs ago _____ |
| <input type="checkbox"/> CABG  | Year or # of yrs ago _____ | <input type="checkbox"/> Plastic Surgery  | Year or # of yrs ago _____ |
| <input type="checkbox"/> Cholecystectomy   | Year or # of yrs ago _____ | <input type="checkbox"/> Prostate surgery   | Year or # of yrs ago _____ |
| <input type="checkbox"/> Colectomy   | Year or # of yrs ago _____ | <input type="checkbox"/> Skin cancer surgery  | Year or # of yrs ago _____ |
| <input type="checkbox"/> Hemorrhoidectomy  | Year or # of yrs ago _____ | <input type="checkbox"/> Thyroid surgery  | Year or # of yrs ago _____ |
| <input type="checkbox"/> Hernia repair -R <input type="checkbox"/> L <input type="checkbox"/>  | Year or # of yrs ago _____ | <input type="checkbox"/> Tonsillectomy  | Year or # of yrs ago _____ |
| <input type="checkbox"/> Hip replacement-R <input type="checkbox"/> L <input type="checkbox"/> | Year or # of yrs ago _____ | <input type="checkbox"/> Other Surgery _____  |                            |

- |   |                |  |
|---|----------------|--|
| <input type="checkbox"/> Pregnancies            | How Many _____ | <input type="checkbox"/> Pregnant now/ planning pregnancy soon |
| <input type="checkbox"/> Vaginal deliveries     | How Many _____ | <input type="checkbox"/> Breastfeeding                         |
| <input type="checkbox"/> C-Section              | How Many _____ | <input type="checkbox"/> Contraceptives                        |
| <input type="checkbox"/> Stillbirth/miscarriage | How Many _____ | <input type="checkbox"/> Hormone Therapy                       |

**FAMILY HISTORY:**

Is there a history in your **Family** of spider or varicose veins?

Describe which:

- |   |   |
|---|---|
| <input type="checkbox"/> Mother _____       | <input type="checkbox"/> Siblings _____   |
| <input type="checkbox"/> Father _____       | <input type="checkbox"/> Aunt/Uncle _____ |
| <input type="checkbox"/> Grandparents _____ | <input type="checkbox"/> Child _____      |

Is there a history in your **Family** of deep venous thrombosis, stroke or clotting disorders?

Describe which:

- |   |   |
|---|---|
| <input type="checkbox"/> Mother _____       | <input type="checkbox"/> Siblings _____   |
| <input type="checkbox"/> Father _____       | <input type="checkbox"/> Aunt/Uncle _____ |
| <input type="checkbox"/> Grandparents _____ | <input type="checkbox"/> Child _____      |

**FAMILY HISTORY:** Do any major medical problems run in your family? Include consideration of the following: diabetes, heart disease, respiratory problems, high blood pressure, kidney disease, cancer, bleeding problems, breast problems, thyroid problems, or gastrointestinal problems. Please list your primary relatives and the states of their health:

	Age	Health Problems	If deceased, age at death	Cause of death
<b>Father</b>				
<b>Mother</b>				
<b>Siblings</b>				
<b>Brother    Sister</b>				
<b>Brother    Sister</b>				
<b>Brother    Sister</b>				
<b>Children</b>				

**SOCIAL HISTORY:**

Marital Status:  Single  Married  Divorced  Widowed

Children:  Yes  No \_\_\_\_\_ # of children

Occupation: \_\_\_\_\_

Job with prolonged:  Heavy lifting  Moderate lifting  Repetitive movement

Sitting  Standing  Walking

Alcohol:  Never  Social  Moderate Have you ever consumed an excess of alcohol? \_\_\_\_\_

Smoking:  Never  Quit - # of Years ago \_\_\_\_\_  Yes \_\_\_Packs/day Total # of years smoked? \_\_\_\_\_

**Medications** with dosage and schedule (or frequency)  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Allergies**  None  Yes

If yes, to what?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of reaction:

**Prior reaction to Lidocaine, Iodine or Latex?**  None  Yes

If yes, to what?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of reaction:

**Review of Systems (Please check all that apply):**

**Constitutional Symptoms**

- Problems with general health
- Recent weight loss
- Recent weight gain
- Fever
- Fatigue
- Night sweats

**Eyes**

- Decreased vision
- Loss of vision
- Discharge
- Double vision
- Eye pain
- Floaters
- Red eyes
- Tearing

**Gastrointestinal Continued**

- Diarrhea
- Changes in bowel habits
- Abdominal pain

**GU-Female**

- Irregular/abnormal periods
- vaginal Discharge
- Nipple Discharge
- Hernia

**GU-Male**

- Infection of penis
- Impotence
- Enlarged prostate
- Penile discharge
- Infected prostate
- Infection of testicle

**Neurological Continued**

- Involuntary movement
- Tremors
- Abnormal numbness/sensation
- Drooping of the face
- Nervousness
- Mental Illness

**Psychiatric**

- Anxiety
- Depression
- Mood swings
- Insomnia
- Hyperactivity
- Night sweats

**ENT, Mouth**

- Sore throat
- Hoarse voice
- Hearing loss
- Tinnitus (ringing of ears)
- Sinus problems

**Cardiovascular**

- Chest pain
- Shortness of breath w/walking
- Shortness of breath while laying flat
- Swelling/leg ankles
- Palpitations

**Respiratory**

- Chronic/frequency of coughs
- Cough/spit up blood
- Wheezing

**Gastrointestinal**

- Difficulty/pain swallowing
- Heartburn
- Nausea
- Vomiting of blood
- Duo/gastric ulcer
- Indigestion
- Jaundice
- Hemorrhoids
- Rectal bleeding
- Pain on defecation
- Black tarry stools
- Constipation

**Musculoskeletal**

- Hip pain
- Knee pain
- Ankle pain
- Shoulder pain
- Wrist pain
- Back pain
- Muscle spasms
- Decreased range of motion

**Integument**

- Rashes
- Skin lesions
- Ulcers
- Itching
- Heavy sweating
- Hair loss
- Easy skin bruising
- Eczema

**Neurological**

- Convulsions
- Dizziness
- Fainting spells
- Loss of consciousness
- Frequent headaches
- migraines
- Disturbances of vision
- Disturbances of smell
- Disturbances of taste
- Disturbances of swallowing
- Difficulty speaking

**Endocrine**

- Heat intolerance
- Cold intolerance
- Altered menses
- Fatigue
- Excessive thirst
- Excessive urination
- Steroid use
- Blood in urine
- Pain/burning urination
- Freq/reoccurring bladder infections
- Kidney infections
- Difficulty passing urine
- Urinating more than 1 per night
- Incontinence

**Blood/Lymphatic System**

- Enlarged lymph nodes
- Fever
- Bruising
- Bleeding tendencies
- Chronic sores

**Allergy/Immunology**

- Rashes
- Itching
- Hives
- Recurrent infections
- Other: \_\_\_\_\_

STEVEN L. KAUFMAN, MD, PhD  
OFFICE POLICY

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We are dedicated to providing you the best care possible. If you have medical insurance we are committed to helping you receive your maximum allowable benefits.

- Payment for service is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express.
- Failure to cancel your office visit within 24 hours of your scheduled appointment will result in a \$50 charge. Failure to cancel your surgery within 48 hours of your scheduled surgery will result in at \$300 charge.
- Returned checks area are all subject to a \$25.00 service fee. Repayment will be required in cash, money order or credit card only.
- Surgery and diagnostic procedures ~ As a courtesy to you, we will assist with your insurance for surgical and diagnostic procedures. We will verify your benefits via phone and when necessary, will obtain pre-authorization or pre-determination prior to your procedure. Insurance providers do not “guarantee” their benefits quoted over the phone. We must emphasize that as a medical provider, our relationship is with you, not your insurance company. Your active participation is necessary when denials occur or payments are delayed from your insurance company. We will file claims forms with your primary insurer and you will be responsible for handling any secondary insurer.
- As the Patient You Have the Ultimate Financial Responsibility. All charges are expected at the time services are rendered by this practice. In the case that private insurance may pay a portion of your charges, your estimated payment (considering expected insurance coverage) will be required to be paid at the time of service. In the event that your insurance provider denies payments or pays less than expected, you are responsible for any balance on your account. The Insurance Company’s decisions and payment amounts are not within our control; however, we are happy to assist you in the insurance appeal process. If it becomes necessary to collect your unpaid using a collection agency, you will also be responsible for any charges incurred as a results of the collection activity (usually 20-50% of unpaid amount) as well as any other legal or court fees incurred.

AGREEMENT

I, (print name) \_\_\_\_\_ understand that I am financially responsible for any remaining balance after insurance processing. I have read and understand the terms and conditions of my financial obligation and agree to honor the office policies outlines above.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**STEVEN L. KAUFMAN, M.D., Ph.D., F.A.C.S.**  
**1136 EAST STUART ST. STE. 4102**  
**FORT COLLINS, CO. 80525**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Name of person (family member or close friend) you approve to receive your personal information \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this **Notice of Privacy Practices** Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Reason: \_\_\_\_\_