ARKTOS
DIRECT CARE

PATIENT INFORMATION SHEET

Patient Name:_____ Date: _____
First Middle Last

Mailing Address:_____ City/State/Zip: _____

Primary Telephone: ( )_____ Secondary Telephone: ( ) _____

Birth Date:_____ Race:_____ Ethnicity:_____ Language:_____

Occupation:_____ Employer: _____

How did you hear about our office?_____

Preferred Pharmacy:_____ Location:_____

We recommend you sign up for the Patient Portal to view labs, statements, etc. online, would you like to sign up? (Must be at least 18 years old) Yes___ No___ E-mail: _____

How do you prefer to be notified of lab results (i.e. phone call, mail, patient portal)?_____

Emergency Contact: _____ Phone:_____ Relationship:_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I give permission for Arktos Direct Care to provide any information about my medical condition, medical needs, medications or the status of my account to the following individual(s):

Name of Designated person: _____ Relationship:_____ Phone:_____

Name of Designated person: _____ Relationship:_____ Phone:_____

☐ I decline any release of information (This does not apply to covered entities listed in the HIPAA rules at 45 CFR 160.103)

Complete this section only if someone other than patient is financially responsible

Responsible Party:_____ Relationship to patient: _____

Mailing address:_____ City/State/Zip: _____

Primary Telephone: ( )_____ Birth Date: _____

Our office will not bill to your insurance for all services. Please remember you are financially responsible for all services provided at our office. Direct primary care members may receive discounted rates for services or included testing.

Patient Signature (or guardian if under 18)_____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to the Patient:

Arktos Direct Care, PLLC ("Practice") is required to provide you with a copy of our Notice of Privacy Practices, which states how the Private Practice may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

Patient's name (please print): _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

The Practice made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the Patient but it could not be obtained because:

☐ The Patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgment.

☐ The Practice was unable to communicate with the Patient.

☐ Other: _____