LONGEVITY MEDICAL CLINIC™

*Feel Younger · Live Better*

# PATIENT CONTACT INFORMATION

We require all new patients to present photo ID. If photo ID does not contain current address, a form of mail correspondence with name & current address is accepted.

Name (First, MI, Last): David B. Thacker

**Billing Address:**

Street: 26255 124th Ave S.E.

City: Kent State: WA Zip Code: 98030

**Shipping Address** (if different from billing address):

Street:

City: State: Zip Code:

**Phone Numbers:** Please check your contact preference.

Home: none Preferred ☐
☐ Authorized to leave detailed information
☐ Leave call back number only
☐ Do not leave message

Work: mobile Preferred ☐
☐ Authorized to leave detailed information
☐ Leave call back number only
☐ Do not leave message

Cellular: 253-312-2224 Preferred ☒
☒ Authorized to leave detailed information
☐ Leave call back number only
☐ Do not leave message

Fax: none
☐ Authorized to leave detailed information

**Email:** underwearmodel10@gmail.com

**Date of Birth:** 03/06/1960 **Gender:** ☒ Male ☐ Female

**Emergency Contact:**

Name: Justin Thacker

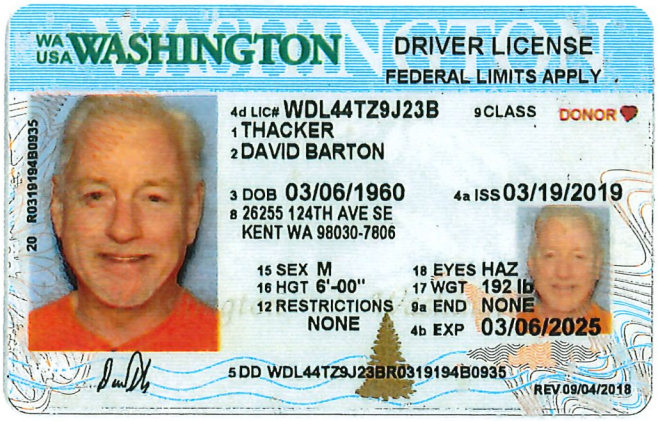
Address: 4312 182nd Ave E.

City: Edgewood State: WA Zip Code: 98371

Phone: 253-230-1717 Relationship:

Are you on Medicare Part B? ☐ Yes ☒ No

**Signature:** [signature] **Date:** 1-20-20


WA
USA WASHINGTON
DRIVER LICENSE
FEDERAL LIMITS APPLY
4d LIC# WDL44TZ9J23B
9 CLASS
DONOR
1 THACKER
2 DAVID BARTON
3 DOB 03/06/1960
4a ISS 03/19/2019
8 26255 124TH AVE SE
KENT WA 98030-7806
15 SEX M
16 HGT 6'-00"
12 RESTRICTIONS
NONE
18 EYES HAZ
17 WGT 192 lb
9a END NONE
4b EXP 03/06/2025
20 R031919480935
5 DD WDL44TZ9J23BR0319194B0935
REV 09/04/2018

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# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Longevity Medical Clinic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Longevity Medical Clinic reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

Additional Disclosure Authorization

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

| | | |
|---|---|---|
| Spouse Only | ☐ YES | ☐ NO |
| Any Member of my immediate family (Spouse, Children, Children's Spouses) | ☒ YES | ☐ NO |
| Any Member of my extended family (Parents, Grandchildren) | ☒ YES | ☐ NO |
| Other | ☐ YES | ☐ NO |
| Name of Patient (please print): David Thacker | Date: 1-20-20 | |
| Patient Signature | | |
| Patient's personal representative (please print) | Date: | |
| Representative's telephone number | | |

*Office use below this line* _____

| Acknowledgement not obtained | | |
|---|---|---|
| Provided prior to visit? | ☐ YES ☐ NO | Date: |
| Reason for not obtaining patient signature: | ☐ Needed more time to review Statement<br>☐ Wanted to consult another person before signing<br>☐ Physically unable to sign<br>☐ No reason offered | |
| Other: | | |