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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): KEN (STONE) J SPICER

Billing Address:

Street: 701 S. MAIN ST, TRLR 48

City: COUPEVILLE State: WA Zip Code: 98239

Shipping Address (if different from billing address):

Street:

City: State: Zip Code:

Phone Numbers: Please check your contact preference.

Home: Preferred ☐
- ☐ Authorized to leave detailed information in voicemail
- ☐ Leave call back number only in a voicemail
- ☐ Do not leave message

Work: Preferred ☐
- ☐ Authorized to leave detailed information in voicemail
- ☐ Leave call back number only in a voicemail
- ☐ Do not leave message

Cellular: 360-774-0168 Preferred ☑
- ☑ Authorized to send appointment reminder text messages (no PHI will be sent via text)
- ☑ Authorized to leave detailed information in voicemail
- ☐ Leave call back number only in a voicemail
- ☐ Do not leave message

Fax:
- ☐ Authorized to leave detailed information

Email: STONESPICER@GMAIL.COM

Date of Birth: 10/28/1941 **Gender:** ☑ Male ☐ Female

Emergency Contact:

Name: KEN SPICER (SON)

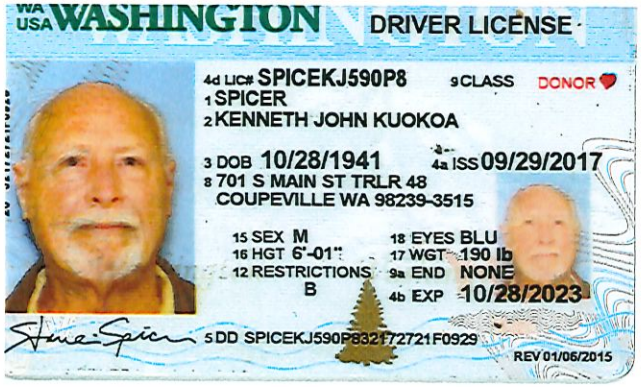
Address:

City: AURORA State: IL Zip Code:

Phone: 713-201-8759 Relationship: SON

Are you on Medicare Part B? ☑ Yes ☐ No

Signature: STONE SPICER **Date:** 10/15/20


WA
USA WASHINGTON DRIVER LICENSE

4d LIC# SPICEKJ590P8 9 CLASS DONOR
1 SPICER
2 KENNETH JOHN KUOKOA
3 DOB 10/28/1941 4a ISS 09/29/2017
8 701 S MAIN ST TRLR 48
COUPEVILLE WA 98239-3515
15 SEX M 18 EYES BLU
16 HGT 6'-01" 17 WGT 190 lb
12 RESTRICTIONS B 9a END NONE
4b EXP 10/28/2023
5 DD SPICEKJ590P832172721F0929
REV 01/06/2015

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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: KEN SPICER	Date: 10/15/20	
Patient Signature: Ken Spicer		
Patient's Personal Representative:	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 ☐ Wanted to consult another person before signing ☐ Physically unable to sign ☐ No reason offered	
Other:		