Acknowledgement of Receipt of Notice of Privacy Practices

Thomas H. Lesnik, M.D.
119 Lafayette Street
Norwich, CT 06360
860 886-1947

Name of Patient:____

I hereby acknowledge that I have been offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:__________________________ Date:____________________

Print Name:_________________________ Telephone:__________________

If not signed by the patient, please indicate your relationship to the patient:________________

For Office Use Only:

☐ Signed form received by:____________________________

☐ Acknowledgment refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

____

Name________________________________ Age_____ Birth Date__________________ Sex________________
FIRST MIDDLE INITIAL LAST

Address____

Home Phone__________________ Cell Phone_______________ Social Security Number_____________________

Height______________________ Weight____________________ Emergency Contact #______________________

Primary Insurance____
INSURANCE CO. ID NUMBER SUBSCRIBER

Secondary Insurance____
INSURANCE CO. ID NUMBER SUBSCRIBER

Employer____ Business Phone____________________________

Marital Status______________________________

Father/Husband Name____
(IF MINOR) FIRST MIDDLE INITIAL LAST DATE OF BIRTH SOCIAL SECURITY NO.

Home address if different____

Employer____ Business Phone____________________________

Mother/Wife Name____
(IF MINOR) FIRST MIDDLE INITIAL LAST DATE OF BIRTH SOCIAL SECURITY NO.

Home address if different____

Employer____ Business Phone____________________________

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THOMAS H. LESNIK, M.D., P.C. FOR SERVICE

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED____ DATE______________________

Past Medical History ____

____

Smoker Yes_____ No_____ If yes, how much ____

Alcohol Consumption Yes_____ No_____ If yes, how much ______________________________________

Drug Sensitivities____

Current Medication____

Sent or Referred by____

Family Physician____

Chief Complaint: