**Ruby Y. Takushi, Ph.D.**
901 Boren Ave., Suite 1930 Cabrini Medical Tower
Seattle, WA 98104 (206) 621-1825

## CLIENT INFORMATION

| Last Name | First Name, Middle initial | (circle) M F | DOB | Today's Date |
|---|---|---|---|---|
| Address: | City, State<br>Zip code | | Home phone<br><br>May I leave my name in messages?<br>(circle one) YES NO | |
| Mailing Address (if different) | City, State<br>Zip code | | Cell phone<br><br>May I leave my name in messages?<br>(circle one) YES NO | |
| Emergency Contact: | Relationship | | Phone Number | |
| (Circle)<br>Single Married<br>Divorced Separated Widowed | Who may I thank for referring you to me?<br><br>Reason for referral: | | | |
| Primary Care Physician<br><br>Prescribing Physician | Date of last Physical Exam<br><br>Current Medications: | | | |

****Please give us your insurance card so we can make a copy. Thank you.**

### Payment Authorization

I hereby authorize the release of the named patient's medical information to insurance companies and other third parties to facilitate health care and processing of claims for this period of treatment.. Such a release may include the contents of my file, unless otherwise specified. I further authorize payment by my insurance company to be made to Ruby Y. Takushi, Ph.D.

Signature:_____ Date: _____

### Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Dr. Ruby Takushi. The Notice of Privacy Practices describes the types of uses and disclosure of my protected Personal Health Information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Notice also describes my rights and responsibilities and the duties of this office with respect to my protected health information. The notice is also posted in the facility.

Ruby Y. Takushi, Ph.D., reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If this occurs, I will be offered a copy of the revised Notice at the time of my first visit after the revisions become effective. I may also obtain a revised Notice by requesting that one be mailed to me. By my signature below I acknowledge that I have received, read, and understood my Rights as it relates to my personal health information.

Signature:_____ Date: _____