ASR, LLC
Advanced Specialty Research

ADVANCED SPECIALTY RESEARCH PATIENT DEMOGRAPHIC INFORMATION

PATIENT CONTACT INFORMATION

NAME:_____DATE OF BIRTH:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PRIMARY PHONE NUMBER:_____SECONDARY PHONE NUMBER:_____

EMPLOYER:_____WORK PHONE:_____

EMAIL ADDRESS:_____SOCIAL SECURITY NUMBER:_____

DO YOU AUTHORIZE / PREFER TO BE CONTACTED BY (Please Check One or More of the Following):

☐ Phone Call ☐ Text Message ☐ E-Mail

EMERGENCY CONTACT INFORMATION

CONTACT NAME	RELATIONSHIP	PHONE NUMBER
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____

ADDITIONAL INFORMATION

MARITAL STATUS:_____SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER_____PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT US?:_____

PRIMARY CARE PHYSICIAN INFORMATION

PHYSICIAN NAME: _____

ADDRESS: _____

PHONE NUMBER_____ FAX:_____

HIPAA CONSENT

In signing this form, you consent to the use and disclosure of your protected health information by Advanced Specialty Research, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You have the right, and we encourage you, to review our NOTICE OF PRIVACY PRACTICES prior to signing this consent. It provides more detail on how we may use and disclose your information. The NOTICE OF PRIVACY PRACTICES may change at our discretion, as necessary. A copy may be requested when you are being seen as a patient or sent to your residence.

You may also revoke this consent in writing. Information on treatment and services provided or prior consents may still be used for purposes of treatment, payment, or health care options. Please refer to the NOTICE OF PRIVACY PRACTICES for further information.

Signature of Patient/Authorized Representative:_____Date:_____
(Must be over 18 for signature)

CONSENT TO TREAT

I attest that I have completed the above information accurately and completely to the best of my ability. My signature below represents consent to be treated by Advanced Specialty Research. This consent encompasses all procedures and treatments as are found to be necessary or desirable, in the judgment of the professional staff of Advanced Specialty Research. I further understand that my consent for treatment may be revoked in writing at any time.

Signature of Patient/Authorized Representative:_____Date:_____
(Must be over 18 for signature)

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

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200 N. 3rd St., STE 110 Boise, Idaho 83702 – Tel: 208.906.1600 – Fax: 208.579.2451

Name:	Date of Birth:	Gender:	Age:
Marital Status: Single, Married, Divorced, Widowed, Engaged, Domestic Partner	Race: White, Asian, African American, American Indian, Alaska Native, Native Hawaiian, Pacific Islander, or Other:_____		Ethnicity Caucasian, Hispanic Latino, or Other:_____

MEDICAL ILLNESSES OR CONDITIONS					
Prior history of condition/diagnosis (check only if applicable)	Dates (if known) MM/YY-MM/YY	Currently on Meds? (check yes)	Prior history of condition/diagnosis (check only if applicable)	Dates (if known) MM/YY-MM/YY	Currently on Meds? (check yes)
☐ Hearing Disorder		☐ Yes	MUSCULOSKELETAL		
☐ Eye disorder		☐ Yes	☐ Gout		☐ Yes
☐ Allergy (seasonal)		☐ Yes	☐ Osteoarthritis		☐ Yes
☐ Infection		☐ Yes	☐ Osteoporosis		☐ Yes
☐ Seizure disorder		☐ Yes	☐ Collagen vascular disease		☐ Yes
☐ Migraine headaches		☐ Yes	☐ Degenerative disc disease		☐ Yes
☐ Transient ischemic attack		☐ Yes	☐ Fractures		☐ Yes
☐ Cerebral vascular accident		☐ Yes	☐ Scoliosis		☐ Yes
☐ Cerebral hemorrhage		☐ Yes	☐ Other Joint Disorders		☐ Yes
☐ Parkinson's disease		☐ Yes	☐ Dental Disorders		☐ Yes
☐ Peripheral nerve disorder		☐ Yes	☐ Back Pain		☐ Yes
☐ Cognitive or psychiatric disorder		☐ Yes	BLOOD		
☐ Depression		☐ Yes	☐ Clotting problems		☐ Yes
☐ Post-traumatic stress disorder		☐ Yes	☐ Anemia		☐ Yes
☐ Sleep apnea		☐ Yes	☐ Other:		☐ Yes
☐ Headache		☐ Yes	GASTROINTESTINAL		
☐ Insomnia		☐ Yes	☐ Peptic ulcer disease		☐ Yes
☐ Anxiety		☐ Yes	☐ GERD		☐ Yes
☐ Anorexia Nervosa		☐ Yes	☐ Liver disease		☐ Yes
☐ Emphysema COPD		☐ Yes	☐ Hepatitis		☐ Yes
☐ Pneumonia		☐ Yes	☐ Pancreatitis		☐ Yes
☐ Asthma		☐ Yes	☐ Gastrointestinal bleed		☐ Yes
☐ Tuberculosis		☐ Yes	☐ Gallstones		☐ Yes
☐ Yeast Infection		☐ Yes	☐ Cholecystitis		☐ Yes
CARDIOVASCULAR			☐ Inflammatory bowel disease		☐ Yes
☐ Angina		☐ Yes	☐ Diverticulitis		☐ Yes
☐ Myocardial Infarction		☐ Yes	☐ Irritable Bowel Syndrome		☐ Yes
☐ Congestive Heart Failure		☐ Yes	☐ Constipation		☐ Yes
☐ High blood pressure		☐ Yes	☐ Hernia		☐ Yes
☐ Cardiac arrhythmia		☐ Yes	☐ Anorexia		☐ Yes
☐ Peripheral vascular disease		☐ Yes	METABOLIC		
☐ Congenital heart disease		☐ Yes	☐ Diabetes Mellitus		☐ Yes
☐ Syncope		☐ Yes	☐ Obesity		☐ Yes
☐ Valvular heart disease		☐ Yes	☐ Hyperthyroidism		☐ Yes
☐ Coronary artery disease		☐ Yes	☐ Hypothyroidism		☐ Yes
☐ Hyperlipidemia		☐ Yes	☐ Hyperparathyroidism		☐ Yes
☐ Hypercholesterolemia		☐ Yes	WHOLE BODY		
☐ Gilbert's Syndrome		☐ Yes	☐ Cancer		☐ Yes
GENITOURINARY			☐ Alcoholism		☐ Yes
☐ Kidney disorder		☐ Yes	☐ Drug abuse		☐ Yes
☐ Kidney Stones		☐ Yes	☐ Drug allergies/reactions		☐ Yes
☐ Bladder pain		☐ Yes	☐ Immune deficiency disease		☐ Yes
☐ Urinary tract infection		☐ Yes	☐ Fatigue		☐ Yes
☐ Tumor of breast		☐ Yes	☐ Weakness		☐ Yes
☐		☐ Yes	☐ Other Allergy (Non-Drug)		☐ Yes
☐		☐ Yes	☐ Fibromyalgia		☐ Yes
☐		☐ Yes	☐		☐ Yes

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MEDICAL ILLNESSES OR CONDITIONS CONT.					
Prior history of condition/diagnosis (check only if applicable)	Dates (if known) MM/YY-MM/YY	Currently on Meds? (check yes)	Prior history of condition/diagnosis (check only if applicable)	Dates (if known) MM/YY-MM/YY	Currently on Meds? (check yes)
DERMATOLOGY (SKIN)			OTHERS NOT LISTED		
☐ Eczema		☐ Yes	☐		☐ Yes
☐ Psoriasis		☐ Yes	☐		☐ Yes
☐ Acne		☐ Yes	☐		☐ Yes
☐ Rosacea		☐ Yes	☐		☐ Yes

First day of last menstrual period?	Date:
Gender assigned at birth (Male/Female):	Gender:

CURRENT MEDICATIONS:		ALLERGIES: (include drugs, foods, chemicals, insects, etc.)		
Drug Name:	Dose:	Item:	Date:	Type of Reaction:

HOSPITALIZATIONS AND SURGERIES			
Reason/Diagnosis/Procedure:	Date:	Reason/Diagnosis/Procedure:	Date:

IMMUNIZATIONS AND PREVENTITVE SERVICES:							
Women Only	Date:	Men Only	For Men and Women over the age of 50:		Immunizations:	
☐ Pap Smear		☐ PSA	☐ Colonoscopy	☐ Stress Test	☐ Tetanus	☐ Pneumonia
☐ Mammogram			☐ EKG / ECG	☐ Eye Exam	☐ Flu/Influenza	☐ Shingles
☐ Bone Density						

PERSONAL HABITS (*Check all that apply*):		
☐ Currently Use Tobacco Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco Amount/Day: Years:	☐ Consume Alcohol Type: Amount/Day: Years:	☐ Exercise Regularly Type: Frequency:
☐ Former Smoker Amount/Day: Years: Quit Date:	☐ Use recreational drugs Type: Frequency: Years:	

RESEARCH STUDY HISTORY
Have you ever participated in a clinical trial? ☐ Yes* ☐ No *If YES – please list the date(s) you were on the trial and as many details of the trial as you can remember (i.e. Sponsor, Study Drug, Indication) 1.
2
3.

ASR, LLC
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AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

THIS IS TO AUTHORIZE THE MEDICAL INFORMATION TO BE SENT TO THE REQUESTING PARTY

TO_____ FROM_____ ADVANCED SPECIALTY RESEARCH

TO_____ FROM_____ _____

Phone_____ Fax_____

TO_____ FROM_____ _____

Phone_____ Fax_____

Purpose or need for records: _____

COPIES TO BE RELEASED: (CHECK ALL THAT APPLY)

- ❑ ALL RECORDS
- ❑ LABS
- ❑ EKG
- ❑ PATHOLOGY
- ❑ X-RAY REPORT
- ❑ PROCEDURE NOTES
- ❑ PHYSICIAN'S/MIDLEVEL ORDERS & PROGRESS NOTES
- ❑ ALCOHOL OR DRUG ABUSE RECORDS _____ (MUST INITIAL TO BE VALID)
- ❑ STD AND/OR AID DIAGNOSIS, HIV, AND/OR HIB TESTS _____ (MUST INITIAL TO BE VALID)
- ❑ BEHAVIORIAL HEALTH/COUNSELING NOTES _____ (MUST INITIAL TO BE VALID)

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM TODAY'S DATE UNLESS REVOKED IN WRITING. THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME WITH THE EXCEPTION OF INFORMATION RELEASED PRIOR TO THE DATE OF THE WRITTEN REVOCATION. ADVANCED SPECIALTY RESEARCH CANNOT CONDITION TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY OF BENEFITS ON WHETHER THE AUTHORIZATION IS SIGNED. PROTECTED HEALTH INFORMATION, ONCE RELEASED, HAS THE POTENTIAL TO BE REDISCLOSED TBY THE RECIPIENT AND IS NO LONGER PROTECTED BY ADVANCED SPECIALTY RESEARCH AND MAY NO LONGER BE PROTECTED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

PARTICIPANT SIGNATURE: _____ **DATE:** _____

PARENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____