***NEW PATIENT DEMOGRAPHICS***

|  |
| --- |
|  NAME: \_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_  |
|  Last First Middle  |  |  |
| Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  Street Address/PO Box City State Zip |  |  |
| Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  |
| Home Phone: Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Marital Status:** Single Married Divorced Widowed  |  |  |
| **Sex:** Male Female Other-describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |   |
|  Race: Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |  |
| Preferred Language: SPOKEN: WRITTEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

***This information is being collected to help monitor quality of care. The Commission to End Healthcare Disparities recommends that all practices collect this data on each patient served.***

**Primary Insurance:**

Primary Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Number: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_

 Street Address/PO Box City State Zip

**Secondary Insurance:**

Secondary Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Number: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_

 Street Address/PO Box City State Zip

**Referring Provider:**

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURED/SUBSCRIBER/RESPONSIBLE PARTY**

Responsible Party/Primary on Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |
| Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |

 |
|  |
| **(Note: *You MUST provide a copy of your insurance card at time of registration at each visit)*** |  |  |
| **EMERGENCY CONTACT**  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  | Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I attest that all information provided is true and correct.**

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***Signature of Patient/Responsible Party Relationship to Patient Date***

**Have you EVER had any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
|  Asthma/Breathing Problems........................ □ Y  | □ N  | Heart Disease/Disorder .............................. □ Y  | □ N  |
| Arthritis........................................................ □ Y  | □ N  | Lung Disorder............................................. □ Y  | □ N  |
| Bleeding/Clotting Disorder........................... □ Y  | □ N  | Liver Disease .............................................. □ Y  | □ N  |
| Blood Pressure Disorder............................... □ Y  | □ N  | Neurological Disorder/Chronic Headaches. □ Y  | □ N  |
| Blood Transfusion ........................................ □ Y  | □ N  | Psychiatric Disorder/Illness......................... □ Y  | □ N  |
| Bowel/Stomach Problems............................ □ Y  | □ N  | Pulmonary Embolism/DVT ......................... □ Y  | □ N  |
| Cancer.......................................................... □ Y  | □ N  | Stroke......................................................... □ Y  | □ N  |
| Cholesterol Disorder .................................... □ Y  | □ N  | Seizure or Epilepsy ..................................... □ Y  | □ N  |
| Diabetes....................................................... □ Y  | □ N  | Thyroid Disorder ........................................ □ Y  | □ N  |
| Eye Disorder (i.e. Glaucoma, cataract) ......... □ Y  | □ N  | Urinary/Kidney Disorder ............................. □ Y  | □ N  |
| **If Relevant:** Gynecological Issues…………….. □ Y □ N  |  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Procedure/ Hospitalization  | Date  | Complications  |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

**Please indicate any major conditions/illnesses that your immediate family members have had:**

|  |  |  |  |
| --- | --- | --- | --- |
| Relative  | Condition and description  | Living?  | If deceased, at what age?  |
| Mother  |   | □ Y  | □ N  |   |
| Father  |   | □ Y  | □ N  |   |
| Sibling  |   | □ Y  | □ N  |   |
| Other:  |   | □ Y  | □ N  |   |

 Do you currently smoke? □ Y □ N If no, previously? □ Y □ N Years smoked Packs/day

 Do you use other tobacco products? □ Y □ N Consume alcohol? □ Y □ N If yes, drinks/week: \_\_\_\_

 **If Relevant:** Any past pregnancies? □ Y □ N How many? \_\_\_\_ How many deliveries? \_\_\_\_\_\_

***ALLERGIES***

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Allergy  | Reaction  |   | Allergy  | Reaction  |
|   |   |   |   |
|   |   |   |   |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication Name  | Dose  |  | Medication Name  | Dose  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|  |   |   |   |

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

**Pharmacy of Choice:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Privacy Section

Patient Name: Date of Birth:

Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If patient is a minor or not competent to sign)

 We often need to contact patients by phone - for example confirm an appointment, return call to patient and lab and cardiac testing results. If you are not available, we will leave a message on your answering machine or voicemail. **If you do not wish us to leave a message on your answering machine or voicemail, check this box.**

***\*\*If you leave this box unchecked, you are giving us permission to leave such messages.***

 We participate in one or more Health Information Exchanges (HIE) which allows disclosure of your electronic health records via electric transfer to other facilities and providers for your treatment purposes. **If you do not wish us to access or allow access through HIEs, check this box.**

***\*\*If you leave this box unchecked, you are giving us permission to use/share your information on a HIE***

Please list the names of persons (including Physicians/Providers) with whom we can discuss the medical condition of the patient, and their relationship to the patient:

|  |  |
| --- | --- |
| **Name**  |  **Relationship to Patient**  |
|   |   |
|   |   |
|   |   |

**Effective today’s date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , I want this consent to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

****

 **Continue Indefinitely**  **Be effective only until (date):**

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and I am aware that my patient rights are identified in the practices’ Notice of Privacy Practices:

Signature of Patient Date

And/Or, Personal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# RELEASE OF MEDICAL RECORDS/INFORMATION

 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Medical Records from **LIFE Family Healthcare, LLC:**

* Sent directly to another provider (practitioner, clinic, hospital) – no fee for service
* For PERSONAL copies, a $30 fee for pages 1-20 and $0.50 for each additional page mayb e charged and is due *at the time* the request is made.
* **Medical Records request may take up to 30 days to be processed.**

**I request and hereby authorize LIFE Family Healthcare, LLC to:**

 **RELEASE RECORDS TO: OBTAIN RECORDS FROM:**

Name of Provider/Facility:

Contact Person: Address:

City: State: Zip:

Phone: Fax:

Service Dates:

**You may use or disclose the following healthcare information (check all that apply).**

 All medical records, laboratory, radiology, diagnostic tests for the time period indicated

 Prescription, diagnostic, treatment, and/or care management services

 Reviews required by HHS or HIPAA-compliant health care operations

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Requests to obtain Medical Records on behalf of the patient above, please FAX requested information to (505)433-2475.**

 ***Signature of Patient/Responsible Party Relationship to Patient Date***

## Controlled Substance Medication Policy

It is the policy of LIFE Family, that Patients with medications such as Narcotics will be referred out to a Pain Management Specialist. These medications will not be maintained and/or prescribed within our practice.

Every patient of LIFE Family Healthcare must sign and acknowledge the Controlled Substance Medication Policy.

**Patient Agreement Statement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and voluntarily agree that (initial each statement after reviewing):

 I will keep (and be on time for) all my scheduled appointments with LIFE Family Healthcare.

 I will follow through with all referrals given to me by LIFE Family Healthcare.

 I will keep the medication safe, secure, and out of reach of children. If the medication is lost or stolen (under any circumstance) it will not be replaced until my next scheduled appointment, and on certain occasions may not be replaced at all.

 I will not call between scheduled appointments requesting refills. I understand that prescriptions will be filled only during scheduled office visits with LIFE Family Healthcare.

 I will make sure I have scheduled an appointment for my refills, and if I am unable to make appointment will give LIFE Family Healthcare 24-hour notice of my cancellation. If 3 or more cancellations and/or no-show appointments, I understand I may be released from LIFE Family Healthcare due to noncompliance of this and other LIFE Family Healthcare policies.

 I will always (under all circumstances) treat LIFE Family Healthcare staff respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped without notice.

 I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

 I will sign a release form to let the provider speak to all other providers that I am under care with.

 I will tell the provider about all other medications that I am taking and let the provider know immediately if there are any changes to my prescriptions.

 I will use only one pharmacy to get all my medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pharmacy Name/Phone Number

 I will not get any controlled substance medications or any other addictive mediation such as benzodiazepines (klonopin, Xanax, valium) or stimulants (Ritalin, amphetamines) without telling a member of LIFE Family Healthcare medical team ***before I fill the prescription.*** I understand that the only exception to this is if I need pain medicine for an emergency arisen and was taken into urgent care or the emergency room.

 I will not use illegal drugs such as heroin, cocaine, or amphetamines. I understand that if I do, my treatment will be stopped.

 I will come in for regular drug testing. I understand that I must make sure the office has current contact information to reach me, and that any missed tests will be considered positive for drugs.

 I will keep up to date with any bills from the office and tell LIFE Family Healthcare immediately if I lose my insurance or cannot pay for treatment anymore.

 I understand that I may lose my right to treatment in this office if I break any part of this agreement.

**LIFE Family Healthcare Program Statement**

We here at LIFE Family Healthcare are making a commitment to work with you in your efforts to get better. To help you we agree that:

* We will help schedule regular appointments for medication refills. If we must cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
* We will refer you to other forms of treatment.
* We will work with other providers you are seeing so that they can treat you safely and effectively.
* We will work with your medical insurance providers to make sure you do not go without medication because of paperwork or other things they may ask of us.
* If certain medications are not covered with your insurance, we will find alternate medications.
* If you become addicted to these medications, we will assist you in receiving treatment to remove the medications that are causing you problems safely, with minimal side effects.

Patient Printed Name

 Signature Date

***AGREEMENT TO AND CONSENT FOR TREATMENT AT***

# LIFE Family Healthcare, LLC

***Carefully read each statement. Initial in the line to the side to indicate your understanding and agreement. Failing to agree may have a negative impact on the care we are able to provide.***

 I acknowledge that I have received a copy of the “***Notice of Privacy Practices,” “No-Show, Late, & Cancellations,” “Telehealth,” and “Insurance, Financial Arrangements/Payments policies for* LIFE Family Healthcare, LLC** and have read and policies, understand my rights, and agree to abide by the guidelines. I further agree that if I had questions, I was given time to ask them and they were answered to my satisfaction.

 \_\_\_\_\_\_\_\_\_ I understand that consent for use and sharing of my information on the ***Privacy Form*** can be revoked by me at any time. I understand why I have been asked to provide consent for sharing of my information and I am aware that my patient rights are identified in the practice’s *Notice of Privacy Practices.*

 I acknowledge that I am fully responsible for all fees for my medical services at **LIFE Family Healthcare, LLC** including the penalty fees for late payments and missing appointments without notice. I further understand that penalty fees are non-refundable and non- transferrable (cannot be used to cover future copays or charges).

 I agree that information exchanged during Telehealth visits will be maintained by LFH, other healthcare providers, and healthcare facilities involved in my care. I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records). I further agree that I will take an active role in preventing the unauthorized use of electronic communications by others or breaches of confidentiality caused by an independent third party or by my own actions.

 I hereby assign all medical and/or surgical benefits generated by **LIFE Family Healthcare, LLC**. to include major medical benefits to which I am entitled including Medicare, private insurance and any other health plan to **LIFE Family Healthcare, LLC**. I authorize the release of information necessary to process a claim.

 I hereby consent for myself or on behalf of the patient identified above (‘the patient”) to medical treatment to be provided by **LIFE Family Healthcare, LLC** and its practitioners and employees.

 ***Signature of Patient/Responsible Party Relationship to Patient Date***