PATIENT INFORMATION Today's Date: _____

Date of Birth: _____/_____/_____ Patient SSN: _____-_____-_____ Married Single Divorced Widowed (Circle One)

Patient's Legal Name: _____ Full Time Student? Y/N (Circle One)

Street Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone Number: _____

**At times our office will need to call you to discuss lab/x-ray results, medications, scheduling, etc... It is Important that you list any and all phone #'s you may be reached at along with the best time to call. If patient is a minor, provide name of parent/legal guardian to ask for.

Home: (_____) _____-_____ Best time to call: _____

Cell: (_____) _____-_____ Best time to call: _____ Carrier: _____

Work: (_____) _____-_____ Best time to call: _____ Extension: _____

**E-Mail _____

Race: _____ Ethnicity: _____ Gender: _____

Patient's Employer_____ **If patient is a minor, parent/legal guardian's employer

Insurance Company Name: _____

Name of Policy Holder: _____ Policy Holder's DOB: _____

SSN of Policy Holder: _____ Relationship to Patient: Self Spouse Parent

Policy Holder's Address: _____

Phone Number: _____ **If a minor, who is financially responsible for charges? _____

I hereby grant permission for the attending physician and medical staff to give necessary medical treatment to myself/patient. I hereby authorize my insurance benefits be paid directly to Life Care Family Practice, P.C., realizing I am financially responsible to pay for any non-covered services. I also authorize the release of pertinent and protected health information to my insurance carrier for the purpose of medical planning and treatment, payment, or other healthcare operations.

Patient's Signature: _____ Parent/Legal Guardian Signature: _____

Patient Communication Preferences

Patient Name: _____ DOB: _____

Patient confidentially is important at Life Care Family Practice. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.
In the event that I need to be reached regarding lab results, account information or for medical reasons, Life Care Family Practice may leave the information as designated:

_____ (Initials) LCFP **may not** leave Test/Lab results or account information with anyone else

_____ (Initials) Test/Lab Results

LCFP can leave my results as follows:

- May call me at _____
- May leave results on answering machine/voicemail at home number listed in chart
- May leave results on voicemail at work _____ (number)
- May leave results on voicemail on cell phone _____(number)
- May leave results with _____ (name)

_____ (Initials) Account Information

- May call me at _____
- May leave account inquiry/information on answering machine/voicemail at home
- May leave account inquiry/information on voicemail at work _____
- May leave account/inquiry/information on voicemail at home _____

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Life Care Family Practice.

My signature indicates that I understand that cell phones/cordless phones are not secured telephone lines. I also understand that my employer may monitor phone calls and/or messages I receive at work. Therefore, confidentiality is not ensured in these cases.

Patient Signature: _____ Date: _____

Cancellation Policy for Life Family Practice

Our office requires that you give us a 24 hour notice prior to your appointment to inform us of any cancellation. This includes lab appointments as well as office visits.

If you are unable to make your scheduled appointment and if it is after hours, please leave a message with the answering service at our office telephone number.

I hereby acknowledge that I will be charged a fee of $25 for ALL NO SHOWS. This fee will need to be paid in full by the next scheduled appointment.

Signature _____

Printed Name _____

Date _____

Thank you,

Life Care Family Practice

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, this practice originates and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____I fully understand and **DECLINE** the terms of this consent.

_____I fully understand and **ACCEPT** the terms of this consent.

_____ Date: _____

(Patient/Guardian Signature)

- **DO NOT** release any private/protected health information to anyone other than myself, unless requested by me in writing.
- **I do hereby request that any of my outstanding test results may be given over the phone or in person to the following individual(s)**

  (Name: _____ Relationship to patient: _____

  (Name: _____ Relationship to patient: _____

This is the only individual(s), other than myself; I authorize information to be given to. By signing below I agree to the following:

I am aware that medical information is considered to be confidential and that when employees or others associated with Life Care Family Practice are discussing my care over the phone, there is not a way of being able to positively verify that they are talking with the above designated person. Therefore, I hold harmless and blameless any person who gives such information over the phone as long as the information given is to the person who states that they are the designated individual listed above.

I understand that this is an attempt to prevent having to make an office appointment for the sole purpose of obtaining labs or other test results. I also understand that there are some results that will not be given to me or anyone else over the phone and an appointment will need to be made to obtain those test results.

Signature: _____ Relationship: _____ Date: _____

Life Care Family Practice
8464 Adair Street
Douglasville, GA 30134
Phone (770)949-9804 Fax (770)949-9842

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____
Date Of Birth:_____
TO:_____
(Please list ALL previous doctors and numbers)
_____
_____

You are hereby authorized to release to:
Life Care Family Practice, P.C.
8464 Adair Street Suite A
Douglasville, GA 30134
Phone (770)949-9804
Fax (770)949-9842

I, _____ hereby authorize you to release my medical records including psychiatric, alcohol, or drug abuse information contained. Specially, the following (request for any and all records is not accepted):

( ) Laboratory Results
( ) Pathology Reports
( ) History/Physical
( ) HIV test results
( ) Radiology Reports
( ) Progress Notes
( ) EKG/Pap Smear
( ) Other:_____

USES
The information is needed for the following purposes (must be checked):
( ) Continued care by the receiving facility/physician
( ) Claims settlement with insurance company
( ) Needed to receive aid by the above named agency
( ) Personal Use
( ) Other:_____

FEES

Fees will apply if the patient is the one requesting records

_____ _____

PATIENT SIGNATURE **DATE**

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Life Care Family Practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply.

Signed: _____

Date: _____

If not signed by patient, please indicate relationship to patient

Relationship: _____

Witnessed by: _____

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

- Patient refused to sign this Acknowledgement.

Date: _____ Time: _____

Employee Name: _____

PRIVACY POLICY

*******THIS PAGE IS FOR YOUR RECORDS*******

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please be sure to review this policy carefully.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health record or medical record, serves as an:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided

Your Health Information Rights

Although your health record is the physical property of the health care practitioner of facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a request restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the director of health information management at 770-949-9804.

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide a health care provider, and specialist with copies of various reports that should assist him or her in treating you if you are referred.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

-*Business Associates:* There are some services provided in our organization through contacts with business associates. Examples include diagnostic services, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that it can perform the job we've asked it to do and bill you and your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.
-*Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
-*Communication with family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
-*Funeral Directors*: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
-*Food and Drug Administration (FDA)*: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance to enable product recalls, repairs, or replacement.
-*Workers Compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
-*Public Health*: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
-*Correctional Institution:* Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
-*Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Effective Date: 01/01/03
Version Number 01

MEDICARE REQUIRES THIS FORM FOR ANNUAL WELLNESS VISIT

Name:_____ DOB: _____

General Health

How is your overall Health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How many times in the last six months have you been to the emergency room? _____

How many times in the last six months were you admitted to the hospital? _____

Current List of Patient's Providers

Type of Specialist	Provider Name
Type of Specialist	Provider Name
Type of Specialist	Provider Name
Type of Specialist	Provider Name
Type of Specialist	Provider Name

Dentist Provider Name Date

Are you Diabetic? ☐ Yes ☐ No *If yes, please list the last date of your eye exam and your doctor.*

Ophthalmologist/Optometrist Provider Name Date

Current List of Medical Suppliers

Please print all suppliers from which you may receive supplies (i.e. Home Health Agency, Diabetes Supplies, Hospice, etc.)

Name of Supplier	Reason
Name of Supplier	Reason
Name of Supplier	Reason

Surgical History

Name of Surgery	Date of Surgery
Name of Surgery	Date of Surgery
Name of Surgery	Date of Surgery
Name of Surgery	Date of Surgery
Name of Surgery	Date of Surgery

Please list hospitalizations, reason and date (other than surgeries above)

Hospitalization	Reason	Date
Hospitalization	Reason	Date
Hospitalization	Reason	Date

MEDICARE REQUIRES THIS FORM FOR ANNUAL WELLNESS VISIT

Name: _____ **DOB:** _____

Immunizations

Pneumonia Shot: Date

Flu Shot: Date

Covid Shot: Date

Tetanus/T-Dap Shot: Date

Shingles Shot: Date

Allergies: Food, drug, other

_____

_____

Personal History: Please mark any that apply

- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic Headache
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Osteoporosis / Osteopenia
- ☐ Peptic Ulcer Disease / Hiatal Hernia
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other: _____
- ☐ Other: _____

Family History

			Medical conditions:
Father	☐ Living	☐ Deceased	_____
Mother	☐ Living	☐ Deceased	_____
Brother(s)	☐ Living	☐ Deceased	_____
Sister(s)	☐ Living	☐ Deceased	_____
Paternal Grandfather	☐ Living	☐ Deceased	_____
Paternal Grandmother	☐ Living	☐ Deceased	_____
Maternal Grandfather	☐ Living	☐ Deceased	_____
Maternal Grandmother	☐ Living	☐ Deceased	_____

Advance Directives (CPT II Codes 1157F or 1158F)

Advance Directive is a general term referring to various documents that appoint an agent or records your wishes when you cannot communicate for yourself. Do you have an Advance Directive? ☐ Yes ☐ No

If no, would you like more information? ☐ Yes ☐ No

If yes, caregiver identification: Name: _____ Phone #: _____

Please check if you have any of the following:

☐ Living will ☐ Instruction Directive ☐ Healthcare Proxy ☐ Healthcare Power of Attorney

MEDICARE REQUIRES THIS FORM FOR ANNUAL WELLNESS VISIT

Name: _____ **DOB:** _____

Medications (Prescriptions, Vitamins, Over the Counter)(CPT II Code 1159F, 1160F)

Do you take all of your mediations as prescribed? ☐ Yes ☐ No ☐ Sometimes ☐ Almost Never

Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
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Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating
Name	Dose	Date started	Condition Treating

Pharmacy

Local Pharmacy	Address	Phone
Mail Order Pharmacy	Address	Phone

Tobacco, Alcohol & Other Substance Use

Do you use any tobacco products? ☐ Yes ☐ No How long?_____ How many per day?_____

Have you formerly used any tobacco products? ☐ Yes ☐ No When did you stop? _____

Are you interested in quitting tobacco? ☐ Yes ☐ No ☐ I don't use tobacco

Do you consume alcohol? If yes, how many per week? ☐ Yes ☐ No ☐ 1-2 ☐ 3-4 ☐ 5+

Do you consume Caffeine products? ☐ Yes ☐ No How much? _____

Recreational drug use (past or present)? _____

MEDICARE REQUIRES THIS FORM FOR ANNUAL WELLNESS VISIT

Name: _____ **DOB:** _____

Nutrition

How many servings of fruits and vegetables do you usually eat each day? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5+

How many servings of fiber or whole grain foods do you usually eat each day? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5+

How many servings of meat, fish, or other protein do you usually eat each day? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5+

How many servings of fried or high-fat foods do you usually eat each day? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5+

How man servings of sugar-sweetened drinks do you usually have each day? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5+

Sleep

How many hours of sleep do you usually get? ☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+

Do you snore or has anyone told you that you snore? ☐ Yes ☐ No

In the past seven days, how often have you felt sleepy during the daytime? ☐ Often ☐ Sometimes ☐ Almost Never ☐ Never

Home & Safety

What is your living situation? ☐ With my spouse or other family ☐ Alone ☐ I don't have a place to live ☐ With a friend or roommate ☐ Other ☐ In a nursing home or assisted living facility/home

Does your home have working smoke alarms? ☐ Yes ☐ No

Do you fasten your seatbelt in vehicles? ☐ Yes ☐ No

Social / Emotional Support

Which of the following applies to you? ☐ I have supportive family ☐ I have supportive friends ☐ None ☐ I participate in church, clubs, or other group activities

How often do you get out and meet with family and friends? ☐ Often ☐ Sometimes ☐ Almost Never ☐ None

Physical Activity

How many days a week do you exercise? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5+

On the days that you exercised, how long did you exercise? ☐ 0-30 min ☐ 30min - 1 hr ☐ More than 1 hr ☐ I Don't exercise

How intense is your exercise? ☐ Light (stretching, slow walking) ☐ Moderate (brisk walking) ☐ Heavy (jogging, swimming) ☐ Very heavy (running fast) ☐ I don't exercise

MEDICARE REQUIRES THIS FORM FOR ANNUAL WELLNESS VISIT

Name: _____ DOB: _____

Functional Status Assessment (CPT II Code 1170F)

Instrumental activities of daily living

Which of the following can you do on your own without help?

☐ All

☐ Shop for groceries ☐ Drive/use public transport
☐ Use the telephone ☐ Make meals
☐ Housework ☐ Take medication
☐ Handle finances ☐ None

Activities of daily living

Which of the following can you do on your own without help?

☐ All

☐ Dress ☐ Bath ☐ Transfer (in/out of chairs, etc)
☐ Eat ☐ Walk ☐ Use the Restroom
☐ None

Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? ☐ Yes ☐ No

Ambulation Status

How long can you walk or move around? ☐ 0-5 min ☐ 0-15 min ☐ 15-30 min ☐ > 1hr

Which of these assistive devices do you use? ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other ☐ None

Do you have trouble with your balance? ☐ Yes ☐ No

Have you fallen in the last six months? ☐ Yes ☐ No

Sensory Ability

Do you have problems with vision? ☐ Yes ☐ No

Do you use eyeglasses or contact lenses? ☐ Yes ☐ No

Do you have problems with hearing? ☐ Yes ☐ No

Do you use hearing aids or other devices to help you hear? ☐ Yes ☐ No

Pain Assessment (CPT II Codes 1125F or 1126F)

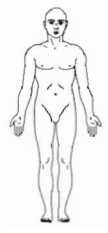
In the past two weeks, how often have you felt pain?

☐ Almost all of the time ☐ Most Times ☐ Sometimes
☐ Almost Never ☐ No Pain

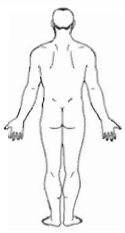
Where is the pain? Mark as indicated on the image:

☐ No Pain

Front:



Back:



How do you treat the pain?

☐ Medication ☐ Other ☐ Therapy ☐ No pain
☐ Rest ☐ No treatment plan ☐ Heat or Cold

Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain: Circle the number on the scale

0 1 2 3 4 5 6 7 8 9 10

No Moderate Worst

Name: _____ **DOB:** _____

Depression (PHQ-9), (HCPCS Code G0444)

In the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things.	☐	☐	☐	☐
Feeling down, depressed, or hopeless.	☐	☐	☐	☐
Trouble falling or staying asleep or sleeping too much.	☐	☐	☐	☐
Feeling tired or having little energy.	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself or that you're a failure or have let yourself or your family down.	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you've been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself.	☐	☐	☐	☐

If you checked off any problems in this section, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not at All ☐ Somewhat
☐ Very Difficult ☐ Extremely Difficult

MEDICARE REQUIRES THIS FORM FOR ANNUAL WELLNESS VISIT

Name: _____ **DOB:** _____

Most Recent Information

Please estimate the date of your most recent:

Any Falls in the Last Year?	Date	Labwork:	Date
Bone Density:	Date	Mammogram:	Date
Colonoscopy:	Date	PAP/Pelvic:	Date
EKG:	Date	Physical Exam:	Date
Eye Exam:	Date	Other: _____	Date

Current Problems You want to Address

Please mark current problems you are having or list complaints you want to address

☐ Rashes	☐ Constipation	☐ Easy Bleeding
☐ Suspicious Moles	☐ Diarrhea	☐ Easy Bruising
☐ Allergies	☐ Change in Bowel Habits	☐ Dry Skin
☐ Cough	☐ Black Stool	☐ Dizziness
☐ Fever / Chills	☐ Reflux (Indigestion)	☐ Fainting
☐ Sinus Problems	☐ Nausea/Vomiting	☐ Night Sweats
☐ Chest Congestion	☐ Blood in Urine	☐ Anxiety
☐ Wheezing	☐ Burning w/ Urination	☐ Depression
☐ Shortness of Breath	☐ Frequent Night Urination	☐ Memory Loss
☐ Swollen Glands	☐ Weight Change	☐ Confusion
☐ Change in Voice	☐ Any Problems w/ Feet	☐ Other
☐ Palpitations	☐ Any Problems w/ Hands	☐ _____