Center for Lifetime Health

Patient Registration

Name (First, MI, Last) _____Date of Birth _____/_____/_____

Preferred Pronouns (please circle all that apply) they/them she/her he/him Other_____

Mailing Address _____City _____State _____Zip _____

Mobile Phone (_____) _____ Work Phone (_____) _____Home Phone (_____) _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated Social Security # _____

Email Address _____

Employer _____ Phone Number (_____) _____

Name of referring physician _____ Phone Number (_____) _____

What is your preferred method of communication? _____

Responsible Party

(If different from above- Statements will be addressed to responsible party)

Name (First, MI, Last) _____Date of Birth _____/_____/_____ Sex: M F

Patient's relationship to Insured: ☐Spouse ☐Parent ☐Child ☐Other _____

Mailing Address _____City _____State _____Zip _____

Home Phone (_____) _____Daytime Phone (_____) _____SS#_____

Employer _____ Phone Number (_____) _____

Insurance Coverage

(If you have a Secondary Insurance, please notify the receptionist)

Name of Policy Holder (Insured) _____ Date of Birth _____/_____/_____ Sex: M F

Insurance Comp. Name _____ Insurance Phone # (_____) _____

Employer _____ Phone Number (_____) _____

Policy # _____ Group #_____

Policy Holder's Social Security # _____

Emergency Contact

Name _____

Relationship to patient _____ Address _____

Mobile phone# (_____) _____ Home phone# (_____) _____

Other Family Members that are also patients: _____

Pharmacy Information

Pharmacy Name_____ Location _____ Fax Number_____

How did you hear about Center for Lifetime Health?

☐Facebook ☐Family or friend ☐Flyer/mailing ☐Google Search ☐Health Insurance

☐Healthgrades.com ☐Healthcare Provider Referral ☐Yelp ☐Other _____

(Patient or Parent Signature Required on Page 2)

CONSENT AND CONDITIONS OF TREATMENT

CONSENT FOR TREATMENT. I voluntarily consent to the care and treatment of the Patient by the Center for Lifetime Health and its affiliated physicians, practitioners, and staff. If Center for Lifetime Health personnel suffer a needle stick or are exposed to blood or body fluids, I consent to the testing of patient for any blood-borne disease for the protection of Center for Lifetime Health personnel.

CONDITIONS FOR TREATMENT AT PRACTICE. In consideration for the care and treatment that Patient will receive or has received at Center for Lifetime Health, I agree to the following:

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS. The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the CENTER FOR LIFETIME HEALTH or insurance company to release any information required to process my claims.

PAYMENT POLICY. Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any **applicable co-payments, co-insurances and/or deductibles will be collected at the time of service.** We accept payment in the form of cash, check or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/all charges not paid for by the insurance company. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is performed, it is the patient's financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such procedure. A fee will be charged for any returned checks.

APPOINTMENT POLICY. Appointments must be confirmed within 72 hours of an appointment, or the appointment will be cancelled. **24-hour notification is required to cancel or reschedule an appointment. Three missed or cancelled same day appointments may result in termination from the practice.** A $25.00 "no show" fee may be charged to your account and is not covered by your insurance for missed appointments.

NOTICE OF PRIVACY PRACTICES. I have received a copy of the Center for Lifetime Health's Notice of Privacy Practices on this or a prior occasion. [Please Initial]: _____

NOTICE OF PATIENT RIGHTS AND PATIENT RESPONSIBILITIES. I have received a copy of the Center for Lifetime Health's, Patient Rights and Patient Responsibilities on this or a prior occasion. [Please initial]: _____

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative and have authority to execute this Consent and Agreement on behalf of the patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction. I, the undersigned, do authorize Center for Lifetime Health and its designees to deliver messages containing account, marketing, or other non-health care messages to the phone number(s) identified above via an automatic telephone dialing system, text messaging or an artificial or prerecorded voice. I understand that I am not required to agree to receive such automated calls/ messages and my agreement is not a condition to receiving items or services from the Center for Lifetime Health. Center for Lifetime Health does not waive and expressly reserves the right to contact patient for any purpose as otherwise permitted by law.

_____ _____

(Print Name) (Date)

_____

(Signature)

_____

Relationship to Patient/Authority

Center for Lifetime Health

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers at Center for Lifetime Health to disclose and release my protected health information described below to:

Name_____ Relationship _____

Contact Information_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
  - Mental health records
  - Communicable diseases (including HIV and AIDS)
  - Alcohol/drug abuse treatment
  - Other (please specify): _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- An electronic record or access through an online portal
- Hard copy

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. 164.524

Center for Lifetime Health

PATIENT HISTORY FORM

Patient Name: _____ Date of Birth:_____

HOME SITUATION: (circle, or add in writing):

Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____) Domestic partnership_____

How many children? _____ How many biological children? _____ Are they healthy? _____

EMPLOYMENT:
Status (please circle): full-time part-time retired disabled homemaker

Occupation _____

HABITS: (circle if applicable):

Smoke/ Smokeless tobacco	Alcohol	Recreational Drugs	Exercise
# packs/day: Quit?	# drinks/week: Quit?	Type: Quit?	How often? Type?

SEXUAL ORIENTATION:
Please circle all that apply: Straight Gay Lesbian Bi-sexual Pan-sexual Queer Asexual Other

PAST MEDICAL HISTORY:
Please list other diseases from which you currently suffer (heart, lung, etc.):

-
-
-
-
-
-

Please list other medical conditions from which you have suffered in the past

-
-
-
-

Please list any surgeries (operations), and/or hospitalizations:

-
-
-
-

ALLERGIES OR ADVERSE REACTIONS TO MEDICATION? (Please list including medication name and type of reaction)

CURRENT MEDICATIONS (including over the counter medications and herbal supplements):

Medications	Dose	How often taken

PHARMACY INFORMATION
Pharmacy Name_____

Location_____Phone number# (____) _____

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives, please mark those who are deceased with a capital D:

Illness/Condition	Father	Mother	P Grandfather	P Grandmother	M Grandfather	M Grandmother
Colon or rectal cancer						
Breast /Prostate cancer						
Ovarian cancer						
Heart disease						
Diabetes						
High blood pressure						
Liver disease						
High cholesterol						
Alcohol abuse						
Drug abuse						
Depression						
Psychiatric illness						
Melanoma						
Genetic (inherited) disorder						
Thyroid disease						
Other						

SYMPTOM REVIEW

Gastrointestinal

- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular

- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular heartbeat
- ☐ history of poor circulation

Pulmonary/lungs

- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone

- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic

- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ numbness or tingling in limbs
- ☐ migraine headaches

General

- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat

- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary

- ☐ frequent or painful urination
- ☐ blood in urine

Skin

- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine

- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only

- ☐ abnormal Pap smear
- ☐ bleeding between periods

date of last mammogram_____

date of last pap smear_____

date of last menses _____

ANYTHING ELSE?

Are there any specific personal issues you would like to bring up at the time of your visit?

Center for Lifetime Health

RELEASE OF INFORMATION

Today's date _____
Patient Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Phone Number _____ Email _____

Records requested from: _____
Address _____ City _____ State _____ Zip _____
Phone Number _____ Fax Number _____

I request and authorize my information to be released to: _____
Address _____ City _____ State _____ Zip _____
Phone Number _____ Fax Number _____

Health Information to be disclosed (check all that apply):

- ○ Billing Records
- ○ Chart Notes
- ○ Lab Reports
- ○ X-ray/Diagnostic Reports
- ○ Medication List
- ○ Immunization
- ○ Appointment Information
- ○ Other: _____

Approximate dates of service (last two years unless otherwise specified): _____

I understand that my medical record may include information on the diagnosis/treatment related to psychiatric, psychological, or mental conditions, drug and/or alcohol use and/or abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV) status, and/or genetic testing. I consent to the following being disclosed: (Please **initial** all that apply)

____ Psychiatric/psychological/mental conditions
____ Drug and/or alcohol use and/or abuse
____ Sexually Transmitted Diseases (STD)
____ Acquired Immune Deficiency Syndrome (AIDS)
____ Human Immunodeficiency Virus (HIV) status
____ Genetic Testing

If expiration date is not specified, this request will expire twelve months from the signature date.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed by this authorization.
I understand that I may revoke this authorization at any time by notifying Center of Lifetime Health in writing, and if I do, it will not have any effect on any actions Center of Lifetime Health took before they received the revocation.
The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care information containing drug and alcohol diagnosis and treatment, mental health and sexually transmitted diseases, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Signature _____ Date _____

Printed Name (if signed on behalf of patient) _____

Relationship to patient _____