Lifedoc Health
825 Valleybrook Dr,
Memphis, TN 38120
Tel: (901) 683 0024
Fax: (901) 683 0086

New Patient Registration Packet

Date of First Visit: ___/___/_____
Who is filling out this questionnaire? Patient___ Other (Specify Relationship)_____

PATIENT INFORMATION
Patient name (Last, First & Middle initial)_____
Date of birth ___/___/_____ Age ____ Social Security #____-___-_____ Sex: M F
Street Address:_____
City:_____ State:_____ Zip Code:_____
Phone Number: _____ Other number:_____
E-mail address:_____
Race: White___ African-American___ Asian ___ American Indian_____ Middle Eastern ____ Other_____
Ethnicity- Hispanic _____ Not Hispanic _____ Other _____
What pharmacy do you want your prescriptions sent to? _____
Phone number_____

PRIMARY CARE INFORMATION
Primary Care Practice Name _____
Primary Care Provider Name _____
Pracitice Phone Number_____

LEGAL GUARDIAN/RESPONSIBLE PARTY (if other than patient)
Name (last, first & middle initial)_____
Street Address_____
City_____ State_____ Zip Code_____
Phone Number_____ Other number_____
Relationship to patient: _____

EMERGENCY CONTACT
Name (last, first & middle initial)_____
Street Address_____
City_____ State_____ Zip Code_____
Phone Number_____ Other number_____

SOCIAL HISTORY
Place of birth:_____ Religion:_____ Education:_____
Occupation:_____ Marital Status:_____
Smoking: Non-smoker Ex-smoker Smoker
If Smoker, how many cigarettes per day?_____
For how many years?_____
If Ex-smoker, how long ago did you stop? _____
Approximately How many alcoholic beverages do you have per day? _____
Current exercise program? Yes or NO
Special diet: YES or NO
Any history of hospitalizations/surgery(include date):_____

_____

_____

Current Medication and doses:

_____ _____

_____ _____

_____ _____

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FAMILY & PAST MEDICAL HISTORY

ILLNESS	Patient	Mother	Father	Siblings	Children	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Aunt/Uncle
Obesity									
Diabetes									
Heart Disease									
Stroke									
High Cholesterol									
High Blood Pressure									
Cancer (with Type)									
Kidney Failure									
Menstrual Irregularities									
Liver Problem									
Thyroid Disorder									
Tuberculosis									
Blood Disorders									
Peripheral Vascular Disease									
Asthma/COPD									
Endocrine Disorders									
Congenital Problems									
Early Puberty									
Seizures									
Arthritis									
Mental Illness (With Type)									
Amputations									
Sleep Apnea									
Mental Retardation									
Eye disease (With Type)									
Blindness									
Neuropathy									
Deceased									
Other									

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HIPAA NOTICE OF PRIVATE PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your Health Information

Each time you visit Lifedoc Health a record of your visit is made. This record contains information about your symptoms, assessments, examinations, test results, medications you take and the plan for your care. This information we refer to as your health or medical record is an essential part of the healthcare we provide for you. Your health record contains personal health information and there are state and federal laws to protect the privacy of your health information.

Uses and Disclosures of Health Information

• Lifedoc Health uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide.
• Lifedoc Health may also use health information about you to call you or send a letter to remind you about an appointment, to follow up with diagnostic tests results, or to provide you with information about other treatment and care that could benefit your health.
• If you were referred to us from another provider, Lifedoc Health may send copies of your medical record to the provider who referred you to us, so your provider will have updated treatment information about your care.
• Lifedoc Health may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes and for emergencies. We also provide information when required by law.
• In any other situation, as for research studies purposes, Lifedoc Health policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Patients' Individual Rights

• You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

• You also have the right to request that we not use or disclose you personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Lifedoc Health will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

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• To exercise any of these rights, your request must be in writing.
Lifedoc Health reserves the right to change this Notice of Privacy Practices and its policies and procedures for privacy practices at any time and to make the changes effective for all protected health information created or received prior to the new effective date and then currently maintained by Lifedoc Health. The revised notices will be posted in office and reasonable efforts will be made to advise you of the change(s) in the Notice, policies and procedures at your next service visit. You may also obtain a copy of the revised Notice upon request.

Concerns and Complaints
For further information on **Lifedoc Health** information practices, or if you are concerned that **Lifedoc Health** may have violated your privacy rights, or you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the **Lifedoc Health** Privacy and Compliance Officer, at *901-683-0024.* You may also send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue, Southwest Washington, D.C. 20201. Complaints to the Secretary must be made within 180 days of when you became aware of, or should have been aware of, the incidents giving rise to your complaint.

ADVANCED DIRECTIVES

Do you have a "Living Will" ? YES ____ NO ____
If your answer is YES, please provide us with a copy for your medical records.

_____ _____
Patient's Name **Patients Signature**

_____ _____
Parent/ Legal Gaurdian Name **Parent/Legal Gaurdian Signature**

_____
Relationship to Patient (If other than self)

Date:_____**/**_____**/**_____

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GENERAL CONSENT FORM

I desire to be treated by Lifedoc Health and its employees and others involved in my care in ways they judge beneficial to me.

I understand that my care will be under the management of Lifedoc Health Provider teams (including but not limited to Physicians, Nurse Practitioners, Physician Assistants, Pharmacists, Optometrists, etc). I understand that my care be provided by Lifedoc Health, which operates supervised training programs.

I understand that I have the right to:
- Ask questions and to receive information about my care and treatment, and
- Withdraw my consent to treatment, immunizations, or tests.

I consent to any services rendered to me or my dependents under general or specific doctor's orders. I consent to:
- X-rays,
- Examination,
- Blood test,
- Laboratory procedures,
- Medications, and
- Other services to treatments to include dental extractions

Rendered or ordered by my health care provider, or rendered by Lifedoc Health's employees, contractors, etc under the instruction, orders, or direction of such provider.

I authorized payment of health care benefits to Lifedoc Health. In addition, I accept personal responsibility for payment of charges for services rendered to me.

I authorize the release of medical or other information needed to process this or any related claim.

I understand that my care in under the management of my attending provider and that Lifedoc Health is not liable for any acts or omissions in following my health care provider's orders.

I understand that no guarantee has been made as a result of care.

_____ _____
Patient's Name **Patients Signature**

_____ _____
Parent/ Legal Gaurdian Name **Parent/Legal Gaurdian Signature**

_____
Relationship to Patient (If other than self)

Date:_____/_____/_____

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Authorization From Legal Guardian to Assist Patients in Receiving Care

THIS FORM MUST BE COMPLETED FOR ANY PATIENTS THAT REQUIRE A LEGAL GAURDIAN PRESENT SUCH AS MINORS, CERTAIN HANDICAPPED INDIVIDUALS, ETC. DO NOT COMPLETE THIS FORM IF THE PATIENT IS AN ADULT AND NO LEGAL GAURDIAN IS REQUIRED TO BE PRESENT.

In the event that the patient has a legal guardian, this form allows specific individuals to assist the patient in receiving care at Lifedoc Health. The form must be completed and signed by the legal guardian of the patient in the event that a legal guardian is required to be present with the patient. This authorization will allow Lifedoc Health to discuss protected health information with the person designated below and the individuals may serve as proxy decision makers for the patient as needed.

Patient Name_____ DOB_____/_____/_____

The following people are authorized to bring my child in for treatment.

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

Unless otherwise identified above, no other individuals will be able to assist the patient in receiving medical treatment at Lifedoc Health. In the event of any issues arising the patient's legal guardian will be contacted using the information on file.

_____ By selecting this option you authorize the people above to serve as Proxy in decision making regarding the patients care

_____ By selecting this option you are stating that only the, the Legal Gaurdian/Responsible Party on file, should be contacted regarding the approval and consent of any medical care that is not considered routine.

This for shall have no expiration date _____

This authorization is only valid until _____/_____/_____

_____ _____

Patient's Name **Patients Signature**

_____ _____

Parent/ Legal Gaurdian Name **Parent/Legal Gaurdian Signature**

_____

Relationship to Patient (If other than self)

Date:_____**/**_____**/**_____

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Authorization for Release of Medical Information

Patient Name: _____

DOB: _____

The following Patient has recently become a patient at Lifedoc Health. I would appreciate it very much if you would send me the medical history and any information you think may be useful to to **FAX # 901-683-0086.** If you have any questions concerning this request, please contact my office at 901-683-0024.

I, _____, hereby authorize to Please Release the Following (Complete one of the following):

1. All medical and health related information _____
2. Only my medical and health related information regarding the following conditions:

_____

_____

_____

Expiration Date

- The expiration date or expiration event for this authorization is _____
- If not expiration date or period is known it will expire 2 years after the date recorded below
- I understand I may revoke this authorization at any time. I also understand that any release of information made prior to my revocation and which was made in reliance upon an authorization shall not constitute a breach of confidentiality.

I understand that my medical record will include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, AIDS and/or HIV status.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released covered by Title 42 of the Code of Federal Regulations.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability ct (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards). **Notice of Re-disclosure:** This information has been disclosed to you from confidential records, which are protected by Federal Law. Further disclosure of this information is prohibited without the specific written consent of the person to whom it pertains. A general authorization for this release of medical or other information is not sufficient for this purpose.

My records should be under the following name:

_____ _____

Patient's Name **Patients Signature**

_____ _____

Parent/ Legal Gaurdian Name **Parent/Legal Gaurdian Signature**

_____

Relationship to Patient (If other than self)

Date:_____/_____/_____

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Insurance or Payment Information

Please provide a copy of your all of your medical, vision, pharmacy, and all other insurance cards at the time of the visit for Lifedoc Health to scan and keep a copy on your file.

Patient's Primary Insurance

Medical Insurance Name_____ Guarantor Name _____

Subscriber ID _____ Termination Date _____

Patient's other insurance information

Medical Insurance Name_____ Guarantor Name _____

Subscriber ID _____ Termination Date _____

Any additional insurance information should also be collected and scanned into the patient chart

Patient Financial Responsibility

I declare that the information is reported above is correct. I also allow Lifedoc Health to use any of my demographic information to lookup additional coverage and file claims to insurances that I may not have reported above. I have been advised and accept responsibility for the payment of any medical services or tests from laboratories not covered by my insurance company, including but not limited to co-payments or rates of taxation of co-insurance, or laboratory. I understand that it is my decision to continue or not with any procedure not covered or paid by the health insurance company and understand the consequences of not proceeding with preferred service. I also agree that this agreement replaces any previous agreement signed by me or my name.

_____ _____

Patient's Name **Patients Signature**

_____ _____

Parent/ Legal Gaurdian Name **Parent/Legal Gaurdian Signature**

Date:_____/_____/_____

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OFFICE POLICIES ON BALANCES

The Healthcare Industry is experiencing a dramatic increase in the cost of malpractice insurance in the state of Tennessee. We appreciate your cooperation and understanding while we endeavor to provide you with the best possible medical care. For your convenience, we accept cash, debit, and most credit cards.

FINANCIAL RESPONSIBILITY: The insurance policy is an agreement between the insured and the insurance company. We expect all patients or their financial guarantors to be fully responsible for knowledge of insurance benefits, as well as fully and directly responsible for all charges regardless of insurance coverage. Please be assured that we will do everything possible to see that you receive your full benefits in a timely manner. In the event your services are not covered, you are responsible for the balance. **If your insurance company has not paid their portion of your bill within 60 days, you will be responsible for full payment at that time.**

OUTSTANDING BILLS AND COLLECTIONS:. You will be expected to pay at least 20% of the outstanding balance at your office visit. Patients who refuse to pay balance will have to reschedule. In addition, in the event that your account becomes past due (over 90 days) and arrangements for payment have not been made, the account may be placed in collection status. Effective January 1, 2016 all past due balances over 90 days will be placed with an outside collection agency. Please note that you will be responsible for all costs of collection including agency fees, court cost and/or attorney fees. Collections status will affect your ability to seek treatment.

PARTICIPATING INSURANCE: COPAY, DEDUCTIBLE AND COINSURANCE: Where we have a participating agreement with your insurance company, we will expect your estimated co-payment and/or co-insurance at the time of treatment. We may also request that you pay any outstanding deductible or coinsurance. Contracts with insurance companies **do not** permit the waiver of these fees under any circumstances.

NON PARTICIPATING INSURANCE: We will submit your insurance claims to your carrier as a courtesy. However, you will be responsible for all charges not covered by insurance. If your insurance denies or reduces payment, you are responsible for all balances not paid. You may receive a discount for services provided.

NO INSURANCE: Payment in full is due at the time of treatment. Established patient follow-up visits start at $88.00 and New Visits start at $120.00.

RETURNED CHECK FEE: You will be charged a $35.00 for each check returned for insufficient funds. Upon receipt of a returned check, your account will be placed in a “Do Not Accept Checks Status” and we will no longer accept checks on your account.
ARRIVAL TIME AND PAPERWORK: Please arrive 15 minutes before your scheduled appointment time in order to complete the necessary paperwork for your visit. This will assist us in keeping the scheduled appointment times. Updating paperwork is required for every visit to the office. In addition, for each visit you will need to have your insurance card and a government issued photo id.

MISSED APPOINTMENTS: Missed office appointments are appointments cancelled with less than 24 hours or that are not kept at all. After three (3) Missed Appointments we will no longer schedule any appointments and you will have to be seen as a walk-in or same day appointment for 1 year.

MEDICAL RECORDS: To obtain copies of your medical records you must sign a Medical Release form. There is a $20.00 processing fee for the first forty pages plus $0.25 per additional page, plus postage. These fees, set forth by Tennessee State law, must be paid in full before your request can be processed. Please allow up to one week for processing. Disability, workman’s compensation, FMLA, etc. The fee for completion of these items is integral to an established patient office visit. You must schedule an appointment for paperwork completion. Communication between the physician and patient is necessary for proper completion of paperwork. All fees must be paid in full before the forms can be produced.
The undersigned agrees that she/he has read and will abide by the office policies of Lifedoc Health.

_____ _____
Patient’s Name **Patients Signature**

_____ _____
Parent/ Legal Gaurdian Name **Parent/Legal Gaurdian Signature**

Date:_____/_____/_____

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NO-SHOW/ CANCELLATION/ LATE ARRIVAL POLICY

Quality care is essential for all of our patients. Please take a moment to review Lifedoc Health's No-Show, Cancelation, and Late Arrival policy and sign your name to acknowledge that you fully understand this policy.

What is a "No-Show"?

A "No-show" is when the patient either

a) Does not show up to the scheduled visit without notifying us.
b) Fails to reschedule at least 24 hours before the scheduled visit time.
c) Cancels the same day of the appointment.

How does a "No-show" impact Lifedoc Diabetes and Obesity Clinic?

- Puts patients' health at jeopardy when they do not arrive for the appointment.
- Prevents other patients from getting highly needed medical care during that period.
- Negative impact occurs on provider's times and how we measure quality of care as a clinic.
- Unnecessary resources get allocated toward patients that do not show-up for appointments.

How to NOT be a "No-Show"

- Provide the most current phone number, email, and address during booking appointments as well as when clinic calls to verify appointment the day before scheduled visit.
- Confirm or reschedule the appointment when you receive text messages and call reminders.
- Always arrive 15 minutes early to have all the paperwork for the visit ready on time.
- Always bring necessary material for the visit which may include insurance card, picture ID, and payment method if you do not have insurance.
- Give at least a 24-hour notice to reschedule/cancel an appointment.

Consequences for being a "No-Show" Three (3) times in One (1) Year

In your records, if you have been a "No-Show" for three appointments which include being a no-show for same day appointments in theyear,you will no longer be able to make appointments and can only be seen as a **WALK-IN or a Same Day Appointment** for Acute Care visits. However, Should you need a well exam or a visit with a specialist (Diabetes, Obesity, Hypertension, etc) you will only be able to **schedule same-day appointments (Neither Future Appointments nor Walk-Ins)** based on the availability of the provider's schedule.

Late Arrival Policy

We understand certain circumstances can cause delays in being late to an appointment, however, if you are late 30 minutes or more you may have to wait until your provider can see you next as patients who arrive at their scheduled times will get priority. If we are unable to accommodate, or you are unable to wait, we will need to reschedule your visit to a future date.

_____ _____

Patient's Name **Patients Signature**

_____ _____

Parent/ Legal Gaurdian Name **Parent/Legal Gaurdian Signature**

Date:_____/_____/_____