



PATIENT INFORMATION SHEET

Last Name _____ First Name _____ MI _____

SSN# _____ - _____ - _____ DOB ____/____/____ Age _____

Address _____ City _____ State _____ Zip _____

Phone #1 (____) _____ ☐ Home ☐ Cell ☐ Work Phone #2 (____) _____ ☐ Home ☐ Cell ☐ Work

Email _____ Preferred method of appt. reminder: ☐ Text ☐ Email

Referred By: _____

Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Race: ☐ White ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Other _____

Ethnicity: ☐ Hispanic-Latino ☐ Non-Hispanic-Latino Language: ☐ English ☐ Spanish ☐ Other _____

Country of Origin: ☐ USA ☐ Other _____

Employment Status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Employer: _____ Occupation: _____

Emergency Contact _____ Relationship: _____

Address _____

Phone (____) _____ Cellular (____) _____

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

Pharmacy (Local): _____ City _____ Phone # (____) _____

Pharmacy Name (Mail Order): _____ Phone # (____) _____

Do you have a Living Will? ☐ YES ☐ NO (If so, please provide us with a copy for your medical chart.)

I hereby authorize LifeWay, Inc. and/or its staff and affiliates to render medical treatment to me as necessary. I fully understand that I am ultimately responsible for payment for all services provided to me and request that payment from my insurance carrier be made directly to LifeWay, Inc. I also understand that by signing below, my insurance carrier has full access to my entire medical records that may include sensitive, personal and confidential information.

Patient's Signature

Date



PATIENT MEDICAL HISTORY FORM

Today's Date: ____/____/____

Name: _____ DOB: ____/____/____ Age: ____

Reason for Visit: _____

Last WELL/PHYSICAL Exam: ☐ Less than 1 year ☐ Greater than 1 year (Date: _____)

DRUG ALLERGIES:	FAMILY HISTORY						
	<i>(Indicate if deceased)</i>	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
	Heart Disease						
	High Blood Pressure						
	Stroke						
	Cancer						
	Glaucoma						
	Diabetes						
	Epilepsy/Convulsions						
	Bleeding Disorder						
	Kidney Disease						
	Thyroid Disease						
	Mental Illness						
	Osteoporosis						

HOSPITALIZATIONS OR SURGERIES			
REASON	DATE	REASON	DATE

MEDICAL HISTORY			
☐ ADD/ADHD	☐ Depression	☐ Hepatitis (☐ A ☐ B ☐ C)	☐ Pneumonia
☐ Allergies	☐ Diabetes	☐ Hernia	☐ Prostate disease/BPH
☐ Anemia	☐ Epilepsy	☐ Herpes	☐ Sexual dysfunction
☐ Anxiety	☐ Gallbladder disease	☐ HIV (Date _____)(State____)	☐ Sinus issues
☐ Arthritis/Joint pain	☐ GI disorder/Acid reflux	☐ Hypertension	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Insomnia	☐ Syphilis
☐ Bipolar disorder	☐ Gout	☐ Kidney disease	☐ Thyroid disease
☐ Bowel irregularity	☐ Headache/Migraine	☐ Neuropathy	☐ Ulcer
☐ Cancer	☐ Heart disease/MI	☐ Osteoporosis	☐ Vascular disease/PVD
☐ Cholesterol high	☐ Heart murmur	☐ Pain chronic _____	☐ Other _____

IMMUNIZATIONS	HABITS	TESTS AND SCREENINGS
COVID vaccine: ____ ____ ____	☐ Smoker _____ packs daily	Colonoscopy: ____ ____ ____
Flu vaccine: ____ ____ ____	☐ Former smoker	Pap Smear: ____ ____ ____
Pneumonia vacc: ____ ____ ____	☐ Never smoked	Mammogram: ____ ____ ____
Tetanus vaccine: ____ ____ ____	☐ Alcohol: Beer Wine Liquor	Bone density: ____ ____ ____
Hepatitis A: ____ ____ ____	☐ Frequency: # _____ Day Week	Eye exam: ____ ____ ____
Hepatitis B: ____ ____ ____	☐ No alcohol consumption	



HEALTH RISK ASSESSMENT

PHYSICAL ACTIVITY

- How many days per week do you exercise?
☐ 3 or more ☐ 3 or less ☐ Currently not exercising
- How intense is your typical exercise?
 - ☐ Light (stretching, slow walking)
 - ☐ Moderate (brisk walking)
 - ☐ Heavy (jogging, swimming)
 - ☐ Very heavy (fast running, stair climbing)

TOBACCO USE

- Tobacco Status:
 - ☐ Never used tobacco (*Skip to next section*)
 - ☐ Former tobacco user
 - When did you quit? _____
 - ☐ Current tobacco user
 - When did you start? _____
 - ☐ Cigarettes ☐ Cigars ☐ Vape ☐ Chew
- Tobacco Daily Usage (*also if former smoker*):
 - ☐ < ½ pack ☐ 1 pack ☐ > 1 pack ☐ 2 packs ☐ > 2 packs
 - ☐ Other: _____

ALCOHOL USE

- Alcohol Intake:
 - ☐ No alcohol consumption (*Skip to next section*)
 - ☐ Beer _____ ☐ Wine _____ ☐ Liquor _____ (# per occasion)
- Alcohol Frequency:
 - ☐ Socially ☐ Once a week ☐ 2-3 week ☐ >3 week ☐ Daily

ILLICIT DRUG USE

- Illegal drug use and/or Prescription drug abuse:
 - ☐ No drug use or abuse (*Skip to next section*)
 - ☐ History of: When did you stop? _____
 - ☐ Current use: When did you start? _____
 - ☐ Name of drugs _____

SLEEP HABITS

- How many hours of sleep do you get each night?
 - ☐ < 3 hrs ☐ 4-5 ☐ 6-7 ☐ 8-9 ☐ 10-11 ☐ > 12 hrs
- Do you snore or has anyone told you that you snore?
 - ☐ Yes ☐ No
- Do you feel sleepy during the daytime?
 - ☐ Always ☐ Often ☐ Sometimes ☐ Rarely

RELATIONSHIP

- Are you currently married or in a relationship with a significant other?
 - ☐ Yes
 - ☐ No

ABUSE

- Has anyone hurt or abused you in the last year?
 - ☐ Yes (☐ Physical ☐ Sexual ☐ Mental)
 - ☐ No

SEXUAL HEALTH

- How many sexual partners have you had in past year?
 - ☐ Not sexually active ☐ 1 partner ☐ 2 or more
- Are your sexual partners:
 - ☐ Male ☐ Female ☐ Both
- Do you use protection against sexually transmitted diseases? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely

NUTRITION

- Fruits and vegetables:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot
- High fiber or whole grain:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot
- Fried or high-fat food:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot
- Sugar:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot
- Caffeine:
 - ☐ None ☐ Some ☐ Moderate ☐ A lot

GENERAL HEALTH

- In general, would you say your health is:
 - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
- How would you describe your mouth and teeth?
 - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
- How would you describe your hearing?
 - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
- How would you describe your vision?
 - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

ADVANCE CARE PLANNING

- Which of the following do you have?
(Please provide a copy to us for your medical record.)
 - ☐ Living Will ☐ Health Surrogate ☐ Power of Attorney
 - ☐ Do Not Resuscitate ☐ None



HEALTH RISK ASSESSMENT

(Age 64+)

ACTIVITIES OF DAILY LIVING

In the past 7 days, did you need help from others to perform everyday activities such as: ☐ Yes ☐ No

Basic Activities of Daily Living (ADLs)

- ☐ Eating
- ☐ Dressing
- ☐ Grooming
- ☐ Bathing
- ☐ Walking
- ☐ Toileting

Instrumental Activities of Daily Living (IADLs)

- ☐ Laundry
- ☐ Housekeeping
- ☐ Shopping
- ☐ Food preparation
- ☐ Transportation
- ☐ Managing finances
- ☐ Managing medications

COGNITIVE SCREENING

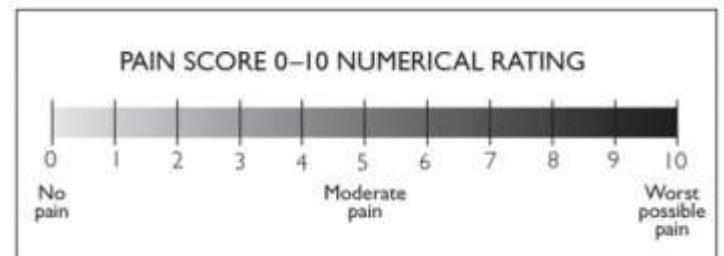
1. Do you have forgetfulness or memory loss?
☐ Yes ☐ No
2. Do you forget important events/appointments?
☐ Yes ☐ No
3. Do you lose your train of thought?
☐ Yes ☐ No
4. Are you overwhelmed by tasks or instructions?
☐ Yes ☐ No
5. Do you have trouble navigating around familiar environments?
☐ Yes ☐ No
6. Are you more impulsive or have increasingly poor judgment? ☐ Yes ☐ No
7. Have family and friends noticed these changes?
☐ Yes ☐ No

FALL RISK ASSESSMENT

1. How many times have you fallen in the past year?
☐ None ☐ Once ☐ Twice ☐ Three or more
2. Have you lost balance causing you to stumble or trip?
☐ Yes ☐ No
3. Do you feel unsteady when standing or walking?
☐ Yes ☐ No
4. Are you worried about falling?
☐ Yes ☐ No

PAIN ASSESSMENT

1. Do you experience chronic pain?
☐ Yes ☐ No
2. In what body area(s) do you experience pain?
☐ Back ☐ Neck ☐ Knees ☐ Hips ☐ Shoulders
☐ Arms ☐ Legs ☐ Hands ☐ Feet ☐ Multiple joints
☐ Other _____
3. If yes, what is your average daily pain intensity?



4. Aggravating Factors: What makes your pain worse?
☐ Sitting ☐ Standing ☐ Bending ☐ Lying down
☐ Other _____
5. Alleviating Factors: What makes your pain better?
☐ Heat ☐ Cold ☐ Massage ☐ Medication
☐ Other _____

DEPRESSION ASSESSMENT PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been
bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

	+		+	
--	---	--	---	--

(Healthcare professional: For interpretation of TOTAL, TOTAL: _____
please refer to accompanying scoring card).

10. If you checked off *any problems*, 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 difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

LifeWay, Inc.

American Urological Association Urinary/BPH Symptom Score Index Questionnaire

Name _____ Date _____

Please fill out this short questionnaire to help us find out more about any urinary problems you might have; for questions 1 through 7, circle the number under the column that best describes your situation; for question 6, circle the number in the row which best describes your situation.

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always
1. INCOMPLETE EMPTYING: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. FREQUENCY: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
2. INTERMITTENCY: Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
3. URGE TO URINATE: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING: Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5+ times
7. URINATING AT NIGHT: Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

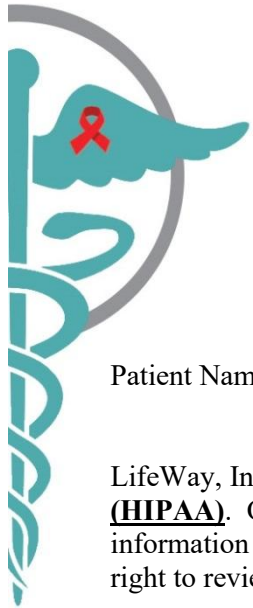
Symptom Score:

1-7 Mild, 8-19 Moderate, 20-35 Severe

Total: _____

BOTHERSOME SCORE DUE TO URINARY SYMPTOMS

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
QUALITY OF LIFE DUE TO URINARY SYMPTOMS: How would you feel if you had to live with your urinary condition the way it is now – no better, no worse – for the rest of your life?	0	1	2	3	4	5	6



Notice of Privacy Practices Consent Form

Patient Name: _____ Date of Birth: _____

LifeWay, Inc. is providing this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

Listed below are the individuals to whom I give permission to LifeWay, Inc., its physicians, staff members and/or representatives, to review and discuss my medical and/or financial issues:

1) Name: _____ DOB: ____/____/____ ☐ Medical ☐ Financial
Phone: (____) _____ Alt. Phone: (____) _____
Relationship: ☐ Spouse ☐ Partner ☐ Mother ☐ Father ☐ Adult Child ☐ Sibling ☐ Other _____

2) Name: _____ DOB: ____/____/____ ☐ Medical ☐ Financial
Phone: (____) _____ Alt. Phone: (____) _____
Relationship: ☐ Spouse ☐ Partner ☐ Mother ☐ Father ☐ Adult Child ☐ Sibling ☐ Other _____

3) Name: _____ DOB: ____/____/____ ☐ Medical ☐ Financial
Phone: (____) _____ Alt. Phone: (____) _____
Relationship: ☐ Spouse ☐ Partner ☐ Mother ☐ Father ☐ Adult Child ☐ Sibling ☐ Other _____

By signing below, I acknowledge that I have read and understand the Patient Privacy Notice from LifeWay, Inc. and consent to the release of information as I have specified above.

Patient's Signature

Date

5333 N. Dixie Highway, Suite 110
Ft. Lauderdale, FL 33334

Office: (954) 772-8554
Fax: (954) 772-9662
Email: info@LifeWayMD.com



FINANCIAL OFFICE POLICY

INSURANCE ASSIGNMENT OF BENEFITS

Thank you for choosing LifeWay, Inc. as your healthcare provider. We are committed to making sure your medical care and treatment is a success. Part of this service includes assisting you with your health insurance needs. Our Billing Department will work with you to ensure your medical claims are filed accurately and promptly.

- **FINANCIAL RESPONSIBILITY**

All amounts predetermined by your insurance policy to be your responsibility are **due in full at the time** services are rendered. Additional amounts may be due after the claim is processed and finalized by your insurance carrier.

- **YOUR INSURANCE POLICY**

Your health insurance policy is a **contract between you and your insurance company**, and we are not a party to that contract. By presenting for care, you agree that you are financially responsible for all services rendered to you and ensuring that they are paid for in full and in a timely manner by you and/or your insurance carrier.

- **COORDINATION OF BENEFITS**

It is mandatory that you **provide us with ALL of your health insurance coverage information**, regardless if we are participating with your insurance or if you are using the insurance. If you have two insurance policies, it is your responsibility to inform both carriers of the presence of other health coverage. There are regulations that dictate which insurance is primary and which is secondary depending on the circumstances relating to your employment, disability status, etc.

- **NEW INSURANCE or CHANGE IN POLICY**

If you have a change in your insurance policy or new insurance, you must **notify us immediately**. This directly impacts all aspects of your care including laboratory testing, medications, specialists, and diagnostic testing. Seeing out of network providers or receiving non-covered services could result in services being denied and becoming your financial responsibility.

- **MISSED APPOINTMENTS**

When you schedule an appointment, you are reserving that time with the provider, thereby making it unavailable to another patient. If you are unable to attend the appointment you have scheduled, it is imperative that you notify us **at least 24 hours in advance**. Failure to do so may result in a **\$35 missed appointment fee**.

- **COLLECTIONS**

If your account becomes past due and/or is referred to a collection agency, you will be responsible to pay all costs and/or collection fees that are incurred in efforts to satisfy your debt. This includes a **\$35 collection processing fee** when outstanding balances are referred to Transworld Systems Inc. for further collection activity, as well as being **subject to dismissal from the practice**.

I have read the above and agree to comply with this policy. I fully understand that I am ultimately responsible for the payment for all services provided to me. I authorize the release of my entire health record and/or any other information necessary, which may contain sensitive information, to process my health claims. I also request that payment of medical benefits be made directly to LifeWay, Inc.

Patient Signature

Date

CONSENT AGREEMENT FOR PROVISION OF CHRONIC CARE MANAGEMENT

Chronic Care Management (CCM) services are available to you because you have been diagnosed with two (2) or more significant chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of functional decline.

By signing this Agreement, you consent to LifeWay, Inc. and its physicians and staff members to provide Chronic Care Management services for you.

CCM SERVICES INCLUDE:

1. 24 hours a day, 7 days a week access to a health care provider to address acute and chronic care needs
2. Continuity of care with designated member of the medical team
3. Systematic assessment of medical needs
4. System-based approach to ensure timely preventative care services
5. Medication reconciliation with oversight and management.
6. Patient-centered plan of care
7. Access to medical records and care plan through a secure and certified electronic health record
8. Coordination of care and facilitating transitions among other health care providers and settings.

PROVIDER'S OBLIGATIONS:

- Explain and offer all of the CCM Services that are applicable to your conditions
- Provide a written or access to an electronic copy of your care plan
- Provide a written confirmation if you choose to revoke this Agreement

BENEFICIARY RIGHTS:

- The Provider will provide you access to a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty (30) day period of services.
 - You may revoke this agreement verbally by calling the office at (954) 772-8554, or in writing to LifeWay, Inc., 5333 N. Dixie Highway, Suite 110, Ft. Lauderdale, FL 33334.
 - Upon receipt of your revocation, the Provider will give you written confirmation, including the effective date of revocation.

ACKNOWLEDGMENT AND AUTHORIZATION:

By signing this Agreement, you agree to the following:

1. You understand the scope of CCM Services and give consent to the Provider to render these services to you.
2. You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of your care.
3. You acknowledge that only one provider can furnish CCM Services to you during a calendar month.
4. You understand that cost-sharing may apply to CCM Services, so you may be billed for a portion of the service if you have a deductible, copay and/or coinsurance with your insurance carrier, even though it does not involve a face-to-face meeting with the Provider.
5. You have the right to stop CCM Services at any time by revoking this Agreement and understand that all services provided in the future regarding any of your conditions will have to be in-person.

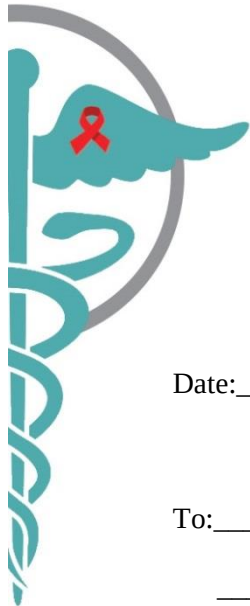
Signature: _____

Print Name: _____

Date: _____

5333 N. Dixie Highway, Suite 110
Ft. Lauderdale, FL 33334

Office: (954) 772-8554
Fax: (954) 772-9662
Email: info@LifeWayMD.com



Medical Records Release Form

Date: _____

To: _____

By signing this form, I authorize you to release my protected health information and entire medical records to LifeWay, Inc.:

Secure Fax Transmission	Mail	Secure Electronic Messaging
(877) 632-8049 (Delivered directly into our Electronic Health Record)	5333 N. Dixie Highway Suite 110 Ft. Lauderdale, FL 33334	drlee@direct.MediTouchEHR.com (*ONLY use if sent from an EHR with Secure Electronic Messaging)

I consent to the release of my complete medical record, including all documentation, test results and reports which may contain confidential health information relating to HIV/AIDS, mental health, and drugs and/or alcohol.

Patient's Name (please print)

Patient's Signature

Date of Birth

Date

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Ft. Lauderdale, FL 33334

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