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 or female □ Asexual □ 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 □ Unemployed □ Retired □ Student □ Disabled

Employer:_____ **Occupation:**_____

Emergency Contact_____ **Relationship:**_____

Address_____

Phone (_____)_____ **Cellular** (_____)_____

Primary Insurance_____ **Policy #**_____

Secondary Insurance_____ **Policy #**_____

- **ARE YOU *ELIGIBLE* UNDER ANY OTHER HEALTH INSURANCE, SUCH AS MEDICARE?** □ YES □ NO
- **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 responsible for payment for all services provided to me and request that payment from my insurance carrier by made directly to LifeWay, Inc. I also understand that by signing below, my insurance carrier(s) has full access to my entire medical records.

_____ _____

Patient's Signature **Date**

PATIENT MEDICAL HISTORY FORM

Name:_____ **Today's Date:**_____

SSN:_____-_____-_____ **DOB:**_____/_____/_____ **Age:**_____ **Sex:** □ Male □ Female

Reason for Visit/Chief Complaint:_____

DRUG ALLERGIES:
CURRENT MEDICATIONS:

FAMILY HISTORY						
(Indicate if deceased)	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						

HOSPITILIZATIONS 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/AIDS	□ Sinus issues
□ Arthritis/Joint pain	□ GI disorder/Acid reflux	□ Hypertension	□ Stroke
□ Asthma/Emphysema	□ Glaucoma	□ Insomnia	□ Syphilis
□ Bipolar disorder	□ Gout	□ Kidney disease	□ Thyroid disease
□ Bowel irregularity	□ Headache	□ Neuropathy	□ Ulcer
□ Cancer_____	□ Heart disease/MI	□ Osteoporosis	□ Vascular disease/PVD
□ Cholesterol high	□ Heart murmur	□ Pain chronic _____	□ Other_____

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

LifeWay

CURRENT PROVIDERS AND SUPPLIERS

Patient's Name: _____ **Date:**_____

In the table below, please list current providers and suppliers that are regularly involved in providing medical care to you.

**(This includes other physicians, specialists, pharmacies, and any other entity involved in your health care.)*

PROVIDER/SUPPLIER	CONDITION/ILLNESS UNDER TREATMENT	START DATE/TIME PERIOD

LifeWay, Inc.

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: □ Partner □ Spouse □ Mother □ Father □ Adult Child □ Sibling □ Other_____

2) Name:_____ **DOB:**____/____/____ □ **Medical** □ **Financial**

Phone: (_____)_____ **Alt. Phone:** (_____)_____

Relationship: □ Partner □ Spouse □ Mother □ Father □ Adult Child □ Sibling □ Other_____

3) Name:_____ **DOB:**____/____/____ □ **Medical** □ **Financial**

Phone: (_____)_____ **Alt. Phone:** (_____)_____

Relationship: □ Partner □ Spouse □ 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 POLICY
ASSIGNMENT OF BENEFITS

Thank you for choosing LifeWay, Inc. as your healthcare provider. We are committed to making sure your treatment is a success. Part of this service includes assisting you with your health insurance needs. Our billing department will work very hard 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 insurances, it is your responsibility to inform both carriers of the presence of other health coverage. There are laws and statutes that dictate which insurance is primary and which is secondary depending on certain circumstances relating to your employer, disability status, etc.

- **NEW INSURANCE or CHANGE IN POLICY**

You must ***notify us immediately*** if you have a change in your insurance policy or new insurance. This directly impacts which laboratory and pharmacy you may use, as well as which specialists you may see, and could result in services being denied and becoming your financial responsibility.

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 to process my claims. I also request that payment of medical benefits be made directly to LifeWay, Inc. If my account becomes past due and/or is referred to a collection agency, I agree to pay all costs and/or collection fees that are incurred in efforts to satisfy the debt.

_____ _____

Patient Signature Date

LifeWay, Inc.

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

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

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

LifeWay, Inc.

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 twelve (12) months or longer.

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

CCM SERIVCES INCLUDE:

1. 24 hours a day/7 days a week access to a health care provider to address acute and urgent 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 review of adherence and potential interactions
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 electronic copy of your care plan
- Provide a written confirmation if you choose to revoke this Agreement

BENEFICIARY RIGHTS:

- The Provider will provide you with 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 thirty (30) day period.
4. You understand that cost-sharing will 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.
    - ***For example, Medicare will allow a monthly reimbursement of $43.61 for CCM services. If you have Medicare Part B, your 20% coinsurance would be $8.72.***
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:_____

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HEALTH RISK ASSESSMENT

PHYSICAL ACTIVITY

- **How many days per week do you exercise?**
  - ☐ More than 3 days per week
  - ☐ Less than 3 days per week
  - ☐ Currently not exercising *(Skip to next section)*

- **How long do you exercise (in minutes)? _____**

- **How intense is your typical exercise?**
  - ☐ Light (stretching or slow walking)
  - ☐ Moderate (brisk walking)
  - ☐ Heavy (jogging or swimming)
  - ☐ Very heavy (fast running or stair climbing)

TOBACCO USE

- Tobacco status:
  - ☐ Never used tobacco *(Skip to next section)*
  - ☐ Former tobacco user
    - How many years?_____
    - When did you quit? _____
  - ☐ Current tobacco user
    - When did you start? _____

- Tobacco product:
  □ Cigarettes □ Cigars □ Pipe □ Smokeless

- Tobacco usage daily:
  □ < ½ pack □ 1 pack □ > 1 pack □ 2 packs
  □ Other:_____

ALCOHOL USE

- Alcohol Intake:
  - ☐ No alcohol consumption *(Skip to next section)*
  - ☐ Beer _____ drinks per occasion
  - ☐ Wine _____ glasses per occasion
  - ☐ Liquor _____ drinks per occasion

- Alcohol Frequency:
  - ☐ Socially
  - ☐ Once per week
  - ☐ 2-3 times per week
  - ☐ More than 3 times per week

ILLICIT DRUG USE

- Illegal and prescription drugs:
  - ☐ No illicit drug use *(Skip to next section)*
  - ☐ History of: When did you stop? _____
  - ☐ Current use: When did you start? _____

- What type of drug(s)?
  - ☐ Cocaine
  - ☐ Crack cocaine
  - ☐ Crystal meth
  - ☐ Heroin
  - ☐ Marijuana
  - ☐ Prescription_____
  - ☐ Other _____

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

DEPRESSION/ANXIETY

- Do you feel down, depressed or hopeless?
  □ Almost always □ Often □ Sometimes □ Rarely
- Do you feel little interest or pleasure in doing things?
  □ Almost always □ Often □ Sometimes □ Rarely
- Have your feelings caused you distress or interfered with your ability to get along with family or friends?
  □ Yes □ No
- Do you feel nervous, anxious or on edge?
  □ Almost always □ Often □ Sometimes □ Rarely
- How often are you not able to stop or control your worrying?
  □ Almost always □ Often □ Sometimes □ Rarely
- Is stress a problem for you in handling things such as your health, finances, relationships or work?
  □ Almost always □ Often □ Sometimes □ Rarely
- Do you get the social and emotional support that you need?
  □ Almost 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 6 months?
  □ Yes
  □ No

SEXUAL HEALTH

- How many sexual partners have you had in the past 12 months?
  □ Not sexually active
  □ 1
  □ 2 or more
- Are your sexual partners:
  □ Male
  □ Female
  □ Both
- Do you use protection against sexually transmitted diseases?
  □ Always
  □ Often
  □ Sometimes
  □ Rarely or Never

ACTIVITIES OF DAILY LIVING

- In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, using the toilet?
  □ Yes _____
  □ No
- In the past 7 days, did you need help from others to take care of such things as laundry, housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your medications?
  □ Yes _____
  □ No

COGNITIVE SCREENING A

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

SLEEP

- 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?
  □ Almost always
  □ Often
  □ Sometimes
  □ Rarely or Never

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 figety 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, please refer to accompanying scoring card). TOTAL:

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 _____

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LifeWay, Inc.

American Urological Association 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