LIVESAY
FAMILY MEDICINE

Dear Valued Patient,

Thank you for choosing Livesay Family Medicine as your new provider. Our goal is to make every interaction you have with our office a pleasant experience.

At Livesay Family Medicine our practice is organized around the patient – communication is based on trust, respect, and shared decision-making. Patients have access to personalized, coordinated, and comprehensive primary care.

It is essential for all new patients/families to provide a complete medical history when establishing care with us, and to share any information about care received outside of our office (hospitals, specialists, etc.). Please complete the enclosed "New Patient Packet", and bring with you to your first visit with Livesay Family Medicine.

WHAT YOU CAN EXPECT FROM YOUR CARE TEAM AT LFM:

- A safe environment to talk about your concerns
- Responses to your questions and concerns at each appointment
- Partnering with you, using shared decision making, to help you manage your health care
- Working together to coordinate care with our office and specialists you see

WHAT YOUR CARE TEAM AT LFM EXPECTS OF YOU:

- Be an active participant on your health care team
- Bring your list of questions and medications to each appointment
- Bring your Photo ID, Insurance Card, and Co-Pay to every visit
- Call our office before going to the emergency room or hospital – we can usually get you into the office the same-day when appropriate
- Inform other providers you may see that LFM is your Primary Care Provider, and ask them to share with us information regarding the care they provided you

Please bring the following items to your first visit:

_Photo ID _Insurance Card(s) _Copay _Medication Bottle(s)	Forms (included in this packet) _New Patient Demographic Form _Patient Responsibilities & Policies _New Patient History Form _ Patient General Consent _ Privacy Practices Acknowledgment

We look forward to serving you and your family with your healthcare needs.

Patient Information							
First Name			Last Name		MI	Date of Birth	
Address			City		State	Zip	
Please Check Primary Phone	_Home Phone		_Work Phone		_Cell Phone		
Other Name(s) Used			E-mail Address				
Gender M / F	SSN		Preferred Language		Driver's License		
Marital Status _ Married _Single _Divorced _Separated _Widowed _Life Partner	Preferred Contact _ Mail _Home Phone _Day Phone _Cell Phone _Patient Portal	Ethnicity _Cambodian _Filipino _Hispanic/Latino _Non-Hispanic	Race _American Indian or Alaskan native _Asian _Black or African American _Native Hawaiian /Other Pacific Islander _White _Other				
Primary Care Provider			Referring Provider				
Responsible Party (Guarantor)				**__ Same as patient**			
First Name			Last Name		MI	Date of Birth	
Address			City		State	Zip	
Please Check Primary Phone	_Home Phone		_Work Phone		_Cell Phone		
SSN	Relationship to Patient		Preferred Language		Driver's License		
Emergency Contact (for minor child this section may be used for other parent)							
First Name			Last Name		MI	Date of Birth	
Address			City		State	Zip	
Please Check Primary Phone	_Home Phone		_Work Phone		_Cell Phone		
Insurance Information							
Primary Insurance			Member ID #				
Name of Policy Holder	Date of Birth		Group #				
Employer			Employer Address				

Patient Name:_____ Date of Birth: _____

Secondary Insurance		Member ID #
Name of Policy Holder	Date of Birth	Group #
Employer		Employer Address

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone

Advanced Directive
_ None _ Do Not Resuscitate _Durable Power of Attorney _Living Will _HC Proxy Date Reviewed:

Medications – List all medications you take, prescriptions and nonprescription, and the dosage	
❑ I do not take any medications	
Medications Name	Dosage

Allergies – List all known allergies (drug, food, animal, etc.)	
❑ No Known Allergies	

For Pediatric Patient	
Patient Resides with: | _Mother |_Father |_Both Parents| _Other:	
Mother's Occupation:	Father's Occupation:
Parent Relationship: |_Married |_Single | _Divorced _Separated | _Widowed	Childcare: | _Mother | _ Father | _Grandparent _Nanny | _Sibling | _Daycare
Tobacco Exposure: | _Yes | _No Smokers at home: | _Yes | _No	Patient is a current smoker? _Yes | _No

Patient Name:_____ Date of Birth:_____

Medical History – Check if you have ever experienced the following conditions, and year of onset

Condition	Year	Condition	Year
❑ None		❑ Gallbladder Disease	
❑ Allergies		❑ GERD (Reflux)	
❑ Anemia		❑ Hepatitis C	
❑ Angina		❑ Hyperlipidemia	
❑ Anxiety		❑ Hypertension	
❑ Arthritis		❑ IBS or IBD	
❑ Asthma		❑ Liver Disease	
❑ Atrial Fibrillation		❑ Migraine Headaches	
❑ Benign Prostatic Hypertrophy (BPH)		❑ Myocardial Infarction	
❑ Blood Clots		❑ Osteoarthritis	
❑ Cancer: ***List Type***		❑ Osteoporosis	
❑ Cerebrovascular Accident		❑ Peptic Ulcer Disease	
❑ Coronary Artery Disease		❑ Renal Disease	
❑ COPD (Emphysema)		❑ Seizure Disorder	
❑ Crohn's Disease		❑ Thyroid Disease	
❑ Depression		❑ Other	
❑ Diabetes		❑ Other	

Surgical History - Check if you have received the following procedures, and year performed

Surgical Procedure	Year	Surgical Procedures	Year
❑ None		MALE ONLY	
❑ Angioplasty		❑ Prostate Biopsy	
❑ Angioplasty w/ stent		❑ TURP (trans-urethral resection of Prostate)	
❑ Appendectomy		❑ Vasectomy	
❑ Arthroscopy Knee		❑ Other	
❑ Back Surgery		❑ Other	
❑ CABG (heart bypass)			
❑ Carpal Tunnel Release		FEMALE ONLY	
❑ Cataract Extraction		❑ Augmentation Mammoplasty	
❑ Cholecystectomy		❑ Bilateral Tubal Ligation	
❑ Colectomy		❑ Breast Biopsy	
❑ Colostomy		❑ Cesarean Section	
❑ Gastric Bypass		❑ D&C	
❑ Hernia Repair		❑ Mastectomy	
❑ Hip Replacement		❑ Myomectomy (removal of uterine fibroids)	
❑ Knee Replacement		❑ Partial Hysterectomy	
❑ LASIK		❑ Reduction Mammoplasty	
❑ Liver Biopsy		❑ Total Hysterectomy	
❑ Pacemaker		❑ Vaginal Hysterectomy	
❑ Small Bowel Resection		❑ Other	
❑ Thyroidectomy		❑ Other	
❑ Tonsillectomy			

Health Maintenance – Check if you have received the following, and date of most recent exam

Exam	Date	Exam	Date
❑ None		❑ GYN Exam	
❑ Breast Exam		❑ Influenza Vaccine	
❑ Cardiac Stress Test		❑ Lipid Panel	
❑ Colonoscopy		❑ Mammogram	
❑ DEXA Scan		❑ PAP/HPV Test	

Health Maintenance cont...			
❑ **Echocardiogram**		❑ **Physical Exam**	
❑ **EKG**		❑ **Pneumococcal Vaccine**	
❑ **Diabetic Eye Exam**		❑ **Pulmonary Function Test (PFT)**	
❑ **FOBT (stool card for hidden blood)**		❑ **Sigmoidoscopy**	
❑ **Diabetic Foot Exam**		❑ **Tetanus Vaccine**	

Family History – Check if any family member(s) have had any of the following conditions.

❑ **Adopted**

Diagnosis	Mother	Father	Brother	Sister	Other
Alcoholism					
Allergies					
Alzheimer's Disease					
Asthma					
Blood Disease					
CAD (Heart Attack)					
Cancer – Type:					
CVA (Stroke)					
Depression					
Developmental Delay					
Diabetes					
Eczema					
Hearing Deficiency					
Hyperlipidemia (High Cholesterol)					
Hypertension (High Blood Pressure)					
Inflammatory Bowel Disease					
Learning Disability					
Mental Illness					
Tuberculosis					
Obesity					
Osteoarthritis					
Osteoporosis					
PVD					
Kidney Disease					
Other:					
Other:					

Social History

Occupation	Employer	
Do you have children?	Male(s)	Female(s)
Tobacco Use? _No Years Used _____	_Daily _Weekly _Less _Former/Year Quit?	_Chew _Pipe _Cigar _Cigarette _E-cigarettes _Smokeless Brand:
Alcohol Use? _No	_Daily _Weekly _Less _Former/Year Quit?	_Beer _Wine _Liquor _ Other
Exercise Activity	_Moderate _Vigorous _Sedentary Days/Week:	Sleep Pattern: _Changes _No changes
Type of Diet	_Regular _Cardiac _Low Carb _Diabetic _Gluten Free _Vegetarian	_Other _____

LIVESAY FAMILY MEDICINE

General Consent (pg 1 of 2)

Assignment of Benefits. I am eligible for the insurance on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Livesay Family Medicine, ("LFM"), all money to which I am entitled for medical expenses related to the services performed from time to time by LFM, but not to exceed by indebtedness to LFM. I authorize LFM to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This means that LFM will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I understand that failure to pay outstanding balances within 90 days of notification of the amount due can result in submission to an outside collection agency. A $25 return check fee will be charged for checks returned due to insufficient funds. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for LFM to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, LFM may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at LFM's expense.

Patient Initials: _____

Electronic Prescription. I understand LFM utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Patient Initials: _____

Electronic Dictation. I understand LFM utilizes HIPAA (privacy) compliant artificial intelligence dictation software through DeepScribe to assist clinicians in documenting patient encounters. *What is DeepScribe?* It is a software program using voice and speech recognition to improve care delivery for our patients and providers' efficiency, by reducing manual data entry. *How does it work?* We use a new technology that uses artificial intelligence and workflows to generate documentation based on recorded audio of patient visits. This significantly reduces the amount of time your clinician spends on documentation and allows more time for providing care to you. The DeepScribe computer software program processes the recorded audio, and we have agreements in place to ensure the confidentiality of your information. All documentation is reviewed, corrected, and approved by your clinician to ensure the accuracy and completeness of your medical record. *Who will listen to the recording?* Your clinician, the medical scribes from our approved service provider, and the computer software will have limited access to the recording. The recordings will remain in the DeepScribe software program for no more than 180 days.

Patient Initials: _____

LIVESAY FAMILY MEDICINE

General Consent (pg 2 of 2)

Phone Calls. By providing contact information, I authorize LFM, its assignees, and third-party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/ employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Patient Initials: _____

Patient Responsibility Policy
I acknowledge receipt of the "Patient Responsibilities and Policies." **Patient Initials:** _____

Notice of Privacy Practices
I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Minor Patient Photograph (when applicable)
I consent for LFM to photograph the minor patient for identification purposes only. **Patient Initials:** _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Information Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive. The practice may condition receipt of treatment upon execution of this consent.

Involvement of Others in Care. I authorize LFM to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification purposes)	Relationship	Phone

❑ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May we contact you by phone, email, or text to confirm appointments and discuss healthcare needs?

Primary Phone #: _____ Secondary Phone #: _____

☐ Leave message with primary contact number only. ☐ Leave detailed information. ☐ Do not leave message.

_____/_____/_____
Print Name of Patient or Personal Representative **Signature** of Patient or Personal Representative **Date**

LIVESAY
FAMILY MEDICINE

Notice of Patient Responsibilities and Policies

OFFICE HOURS: Appointment times are Monday 8:00am – 6:00pm, Tuesday and Wednesday 8:00am – 5:00pm, Thursday 8:00am – 6:00pm and Friday 8:00am – 1:00pm. To schedule an appointment please call our office at (423) 419-5550. Walk-ins are accepted and seen on a first come, first serve basis, by the available provider. Please understand, without an appointment we are working you into the schedule. We will do our best to have you seen in a timely manner.

LATE APPOINTMENT ARRIVAL: We strive to see all patients on time for their scheduled appointment. If you are a returning patient, please plan to arrive 5 minutes prior to your scheduled appointment to check in. New patients, please arrive 15-30 minutes prior to your appointment to ensure we have your "New Patient" paperwork completed. If you arrive 15 or more minutes late for your appointment, you may be asked to reschedule for the next available appointment time.

MISSED APPOINTMENT: A missed appointment is when you fail to show up for an appointment without a phone call, fail to cancel within one business day, or arrive 20 minutes past your scheduled appointment time. If you miss your appointments, you compromise the care that we are able to provide you and other patients. Three (3) or more NO SHOWS for scheduled appointments, in a 12-month rolling period, can result in dismissal from the practice.

PRESCRIPTION REFILL: If you have a refill request, please review your upcoming appointment date and check with your pharmacy for a refill. If you do not have a refill on file at your pharmacy, and will be out of medication before your upcoming appointment, then please contact the office to speak to a nurse. If a nurse is not available at the time of your call, please leave a detailed voicemail with your Name, DOB, Medication Name and Dosage, and your preferred Pharmacy. Please allow 72 hours for processing and a nurse to contact you.

MINORS: Patient's under 18 years of age must be accompanied by one parent, or legal guardian, in order to be seen.

PHONE MESSAGES: In order to provide the best care to our patients, and allow our scheduled patients to be seen without multiple interruptions, our medical staff are available to take messages during office hours. When leaving a message with a staff member, or through the automated voicemail system, please leave your *Name, the Patient's Name, the Patient's DOB, Reason for Call, and good Contact Phone Number* where you can be reached. The medical staff will alert the provider and will respond in a timely manner. Please be aware some messages/questions may require an office visit with the provider.

AFTER HOURS: After hours call service is provided for ***urgent*** medical needs only, by calling our office phone which will forward to an answering service, in which the provider will be contacted. For all ***emergent*** needs please call 911.

PATIENT FORMS: There is a fee that must be paid prior to provider completing the form. Fee schedule is listed at the end of the form section. For completion of forms such as, but not limited to, FMLA, disability forms, jury duty etc., please allow 6 *business days* for our office to complete. *We require the patient, or patient representative, to complete all patient portions of forms prior to bringing to the office, and provide any information needed to assist in completing the form.* Some forms may require an office visit to be completed. **$10 (1 pg. Form), $15 (2 pg. Form), $25 (3+ pg Form).**

MEDICAL RECORD REQUESTS: We offer an online patient portal for the most convenient way to receive medical records. Please ask to sign up when you check in for your next appointment. You may also request a single copy of your lab results at no charge, when the results are given by one of our staff or providers. In order to receive a copy of multiple pages of your medical record, a completed medical release form must be submitted to our office. Please allow up to 30 days for the request to be processed. We strive to complete all medical record requests in a timely manner.

FINANCIAL RESPONSIBILITY: As a patient, it is in your best interest to know and understand your insurance plan benefits, as well as your responsibility for deductibles, co-insurance, or copayment amounts, prior to any visit. Please have your current insurance card(s) with you at all visits, as well as a current photo ID. You are responsible to notify us of your insurance plan(s), and to provide us the necessary information about your insurance policy. It is your responsibility to know your insurance company's patient responsibilities and procedures, and if services are a covered benefit. If your insurance plan does not cover a service, or procedure, you are responsible for payment of these charges. To find out what your insurance plan covers and what your financial obligation may be, call the customer service/member services department (the phone numbers on your insurance card) for assistance. If you do not have insurance coverage on the date of service, please notify us when you schedule the appointment. Payment for services is due at the time of the visit. Resolution for any outstanding balance is expected prior to obtaining additional services from Livesay Family Medicine, P.C.

PREAUTHORIZATION & REFERRALS: Some insurance plans may require a prior authorization, or referral, for services and tests. It is the responsibility of the patient to know your insurance policy's patient responsibilities and procedures. If proper insurance procedure is not followed, you may be liable for full payment of a service or test. If your insurance company requires a referral and/or prior authorization you must contact our office at least six (6) business days prior to seeing a specialist, or having a test performed.

HIPAA NOTICE OF PRIVACY PRACTICES: Protecting the privacy of the health information of our patients is important to us. Within the Livesay Family Medicine Notice of Privacy Practices we are pleased to tell you about a federal law that is designed to help protect the privacy of health information and explains our use of your medical or health information. The law is known as the HIPAA Privacy Rule. The privacy rule requires us to give you access and copies of our Notice of Privacy Practices. Please review the copy attached to your new patient packet, view the copy posted in our lobby, or request a copy from our office staff.

Please do not hesitate to contact our office at (423) 419-5550 with any questions or comments.

LIVESAY FAMILY MEDICINE Tom Livesay, MD | Emily Clotfelter, PA-C | Ashley Wilson, FNP- BC
200 Nettleton Road, Suite 1 Harrogate, TN 37752-8260 | (P) 423.419.5550 (F) 833.944.2041

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ SSN #: _____

I request and authorize _____ to release healthcare information of the above-named patient:

TO:
Livesay Family Medicine
200 Nettleton Rd, Suite 1
Harrogate, TN 37752-8260

This request and authorization applies to:

- ❑ All healthcare information
- ❑ Lab work: Specify _____
- ❑ Imaging: Specify _____
- ❑ Consult Notes: Specify _____
- ❑ Other: Specify_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

_ Yes _No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

_Yes _No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION REMAINS IN EFFECT FOR 365 DAYS AFTER SIGNED, OR UNTIL REVOKED IN WRITING TO LIVESAY FAMILY MEDICINE.