Louisville Lifestyle MEDICINE

___ New Patient
___ Existing Patient

Existing Patient: Please revise all information that has changed since your last visit

Date ___/___/____ Last Name_____First Name_____MI_____

Street Address: _____

City: _____ State _____ Zip_____

Cell Phone_____ Home Phone_____Work Phone_____

E-mail Address:_____

Gender: Male___ Female___ SSN: _____ - _____- _____ Birth-date ____/____/_____

Referring Physician:_____

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other _____

Patient Employed by: _____

Business Address_____

Business Phone: _____ Occupation _____

Name of Spouse/Responsible Party (If patient is minor): _____
Last First MI

Spouse/Responsible party Employed by: _____

Business Address: _____

Business Phone: _____ Occupation _____

Responsible Party/Spouse SSN: _____-_____-_____

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

*This information is required by HIPPA

In case of an emergency, who should be notified? _____

Relationship _____Phone: _____ How did you hear about us? _____

Preferred Pharmacy & zip code: _____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize_____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Louisville Lifestyle Medicine all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. **I understand I am financially responsible for charges incurred**.
I further acknowledge that any insurance benefits, when received by and paid to Louisville Lifestyle Medicine will be credited to my account, in accordance with the above said assignment.

_____ _____
Authorized Signature of Subscriber Date

Email Policy

I authorize the use of _____, my email address, as a form of correspondence of my medical information with Louisville Lifestyle Medicine's providers. I may cancel the use of this email address for correspondence of my medical information at any time by giving written notice to the address listed below.

_____ _____
Signature of Patient/Legal Guardian Date

Consent for Treatment

I (or my legal guardian/parent) authorize Louisville Lifestyle Medicine to provide medical care reasonable by today's standards.

_____ _____
Signature of Patient/Legal Guardian Date

Medicare Authorization
IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to Louisville Lifestyle Medicine for any services furnished to me by LLM. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date

LOUISVILLE LIFESTYLE MEDICINE

Consent to Treatment; Authorization to Release Information; and Statement of Financial Responsibility

Patient Name:_____ **Date:**____/____/____

Louisville Lifestyle Medicine (LLM) appreciates the confidence you have shown in choosing us to provide for your medical needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your provider elect to continue treatment past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at LLM, mailed to the address on your statement, or by calling our office at 502-365-4545.

I have read the above policy regarding my financial responsibility to LLM for providing medical services to the above-named patient or myself. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to LLM. I agree to pay LLM the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature:_____(relationship to patient: self – guardian – other:_____) **Date:**_____

You agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account. We may also contact you by sending text messages or emails, using any email address you provide to us.

Signature:_____(relationship to patient: self – guardian – other:_____) **Date:**_____

I acknowledge that the Notice of Privacy Practices and Notice for Federal Civil Rights is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:**_____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I am aware of my diagnosis and voluntarily consent to have LLM, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my provider. I understand the practice of medical treatments is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that I have the right to ask questions at any time during the course of my care.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:** _____

I further authorize LLM to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment necessary to secure payment for services provided.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:**_____

Louisville Lifestyle MEDICINE

REMINDER

MISSED APPOINTMENT POLICY

We are pleased that you have chosen us to provide your care. Should you miss your scheduled appointment, either medical or aesthetic, it inconveniences not only our staff but also those individuals who need access to our office in a timely manner.

Our office implemented a missed appointment policy beginning August 15, 2018.

A missed appointment is when you fail to show up for a scheduled appointment, or if you do not call (e-mails or texts will NOT be accepted) to cancel within 24 hours of the scheduled appointment time.

Our relationship with you is built on mutual trust and respect. As such, we strive to be on time for our scheduled appointments and ask that you give us a courtesy phone call 24 hours ahead when you are unable to keep your appointment.

Please work with us to provide you with the best possible care you deserve.

All scheduled office visits:

1. First (1st) missed appointment: You will be charged a missed appointment fee of $50.00, you may reschedule your appointment only after missed appointment fee is paid.
2. Second (2nd) missed appointment: You will be charged a missed appointment fee of $50.00, you may reschedule your appointment only after missed appointment fee is paid.
3. Third (3rd) missed appointment: You will need to pay ahead of time full price of appointment for next appointment.

Name (printed):_____ date:_____

Signature:_____

Louisville Lifestyle Medicine
New Patient Information PT (page 1 of 4)

Last Name:_____First Name:_____E-Mail Address: _____

Address:_____City/State/Zip:_____

Date of Birth:____/____/____ Age:_____Sex:_____Social Security Number _____

Marital Status:_____Cell Phone:_____Home phone: _____

Employer/School: _____Occupation: _____

Employer Address:_____Work Phone No: _____

Spouse (or parent, if minor):_____Phone No: _____

Spouse (or parent, if minor) Employer:_____ Address:_____

Contact person outside of home:_____Phone No.: _____

Referring Physician:_____Primary Care Physician:_____

If Minor Child, name of Guarantor:_____Relationship: _____

Address if different than above: _____

Onset Date (injury, accident, or recent date symptoms started):____/____/____did you have Surgery? ☐Y☐N Date:____/____/____

Was this injury the result of a Motor Vehicle Accident? ☐ Work related injury ☐ ***(if Yes please provide injury date above)***

W/C or MVA Insurance Company_____Adjuster Name_____Claim #_____

Health Ins. Co._____ID #_____Policy Holder _____

Would you like appointment reminders: ☐Y☐N: If yes, would you like them by: **Phone** ☐ **Email** ☐ **Text** ☐

How did you hear about us? Family/Friend ☐ **Referral** ☐ **Internet** ☐ **Other** ☐

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize LLM to disclose my health information that is directly related to my current treatment at LLM to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

Name:_____Relationship:_____

Name:_____Relationship:_____

Signature:_____(relationship to patient: self – guardian – other) **Date:**____/____/____

PT Medical Screening Form – (page 2 of 4)

Name:_____ Date:_____

Diagnosis from referring physician:

_____

_____

In the past month, have you frequently been bothered by feeling down, depressed or hopeless?.....Yes ... No

In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things?..... Yes ...No

Do you have a problem with?(check all that apply)

- ☐ Hearing
- ☐ Speech
- ☐ Vision
- ☐ Communication

Do you regularly exercise?.....Yes ... No

Number of days per week?_____ Number of minutes per session?_____

Please list any medicine allergies you may have:_____

Are you allergic to Latex? Yes...No Adhesives? Yes...No

Please list or provide a copy of the medications you are currently taking: (dosages not necessary)

_____

In the Past 3 Months, Have You Experienced:

Unexplained change in your health? Yes...No

↳If yes, please describe:_____

_____

Explained illness or injury? Yes...No

↳If yes, please describe:_____

_____

Unexplained weight change? Yes...No

Night sweats? Yes...No

Fever? Yes...No

Numbness or tingling? Yes...No

Changes or difficulty with bowel? Yes...No

Changes or difficulty with bladder? Yes...No

Please list any major surgeries in your past

_____

_____

_____

Other:

_____

_____

_____

_____

_____

Women:

Are you or could you be pregnant? ..... Yes ... No

Patient/Representative Signature:_____ Therapist Signature:_____

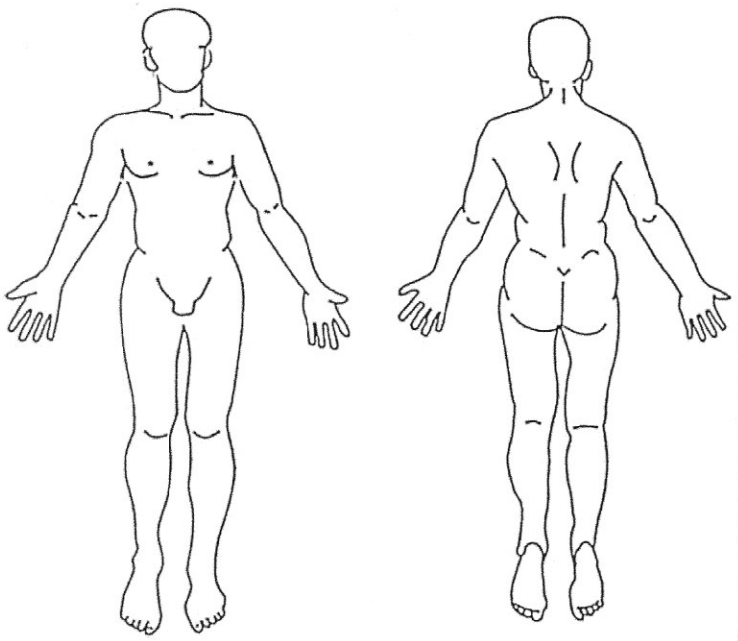
Medical Screening Form – (page 3 of 4)

Name:_____ Date:_____

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = oooooooo Stabbing = //////////
Burning = XXXXXX Deep Ache = ZZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain or symptom on the following line:

_____

0 1 2 3 4 5 6 7 8 9 10

(**0** = none→**10** = worst imaginable. Indicate level foreach with B, C, and W)

What makes your pain or symptom worse?

_____

What makes your pain or symptom better?

_____

Are your symptoms: (check one)
□ Getting worse □ The same □Improving

How are you able to sleep at night? (check one)
□ Fine □ Moderate Difficulty □Only with Medication

Do you have pain at night? Yes ... No

When (date) did your problem begin? _____

Have you been treated for this before? Yes ... No
When? How?_____

PATIENT SPECIFIC FUNCTIONAL SCALE

Please list three (3) activities that you are having difficulty performing. Please rate your ability next to each activity

(**0** = unable to perform → **10** = can perform normally)

1. _____
   _____
   0 1 2 3 4 5 6 7 8 9 10
2. _____
   _____
   0 1 2 3 4 5 6 7 8 9 10
3. _____
   _____
   0 1 2 3 4 5 6 7 8 9 10

Other Relevant Information?_____

_____

_____

_____

Patient or Representative Signature:_____ Date: _____

Reviewer Signature/Initials:_____ Date: _____

Medical Screening Form – (page 4 of 4)

Name:_____ Date:_____

How did this injury/exacerbation occur?_____

Have you had any falls this past year: YES NO If yes, how many?_____

Have you ever had any of the following? (circle) EMG CT SCAN MYELOGRAM MRI XRAY

Have you ever, or are you presently being treated for any of the following conditions:

Acquired Respiratory Distress Syndrome	YES	NO
Angina	YES	NO
Anxiety or Panic Disorders	YES	NO
Arthritis (RA or OA)	YES	NO
Asthma	YES	NO
Chronic Obstructive Pulmonary Disease	YES	NO
Congestive Heart Failure (CHF)	YES	NO
Degenerative Disc Disease (back diseases, spinal stenosis, severe chronic back pain)	YES	NO
Depression	YES	NO
Diabetes	YES	NO
Emphysema	YES	NO
Hearing Impairment	YES	NO
Heart Attack	YES	NO
Multiple Sclerosis	YES	NO
Osteoporosis	YES	NO
Parkinson's Disease	YES	NO
Peripheral Vascular Disease	YES	NO
Stroke or TIA	YES	NO
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	YES	NO
Visual Impairment (glaucoma, macular degeneration, cataracts)	YES	NO