Canna Lifetime

PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____

_____

II. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? YES_____ NO_____

III. Please print the telephone number where you want to receive calls about your appointment, lab and x-ray results, or other health care information if other than your home phone number: _____

IV. In case of emergency notify
Name:_____ Phone:_____

PATIENT NAME_____ (guardian if under18 years)

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

Authorizations

I authorize and consent to medical care and/or minor surgical care deemed advisable by the doctor on duty at the time of my visit in order to diagnose and provide treatment. I authorize the release of external prescription history. I understand that any lab specimens drawn or collected that are not performed here will be sent to an independent laboratory and will be billed separately by the independent laboratory. I agree to be fully responsible for all charges including any legal fees and/or collection fees in the event of non-payment. I authorize Lifetime Family Urgent Care to release any and all medical information in connection with services rendered for health insurance purposes. I give my permission to send a copy of medical records to my primary care physician. I also release Lifetime Family Urgent Care from any liability which may arise as a result of the use of information contained in the records listed. I certify that the information I furnish is true and correct. I know that it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Payment of Benefits

I understand that Lifetime Family Urgent Care will bill my insurance if I have provided adequate information (ID and Insurance card). I authorize payment of benefits by my insurance company directly to Lifetime Family Urgent Care for any medical and/surgical services. I agree that after 60 days all balances due become my responsibility regardless of insurance coverage. I also agree that all charges not paid by my insurance company will be my responsibility. The undersigned &/or patient shall remain responsible for all charges, applicable co-payments and deductibles.

Terms

If no insurance coverage, full payment is required at time of service. There will be a $35.00 charge on any checks returned by your bank.

I certify that the information I have furnished is true and correct. I have read, understand and agree to the policies and terms above.

Printed Name: _____ Date: _____

Signature: _____

PATIENT ACKNOWLEDGEMENT FORM

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. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice to Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this consent

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Patient Name (print): _____

This Acknowledgement was signed by: _____
Patient Signature

Relationship to Patient (if other than patient): _____

Date: _____/_____/_____

Witness Signature: _____
Practice Representative

Date: _____/_____/_____

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Medical History

Date ____/____/____ Age _____

Patient's Name _____ Date of Birth____/____/____

Form completed by _____ Relation (if other than patient) _____

Sex: □ Male □ Female If female, are you pregnant? □ Yes □ No Number or children _____

***** What medical concern brings you in today?** _____

Current Medical History Are you a smoker? □ Yes □ No
Do you drink alcohol? □ Yes □ No
Do you use recreational drugs? □ Yes □ No

Current Medications

Medication	Dosage	How often do you take

Drug Allergies? □ Yes □ No Describe: _____

What is your pharmacy name & number? _____

Past Medical History Have you ever been hospitalized or had surgery? □ Yes □ No

If yes, please list reason or surgeries _____

Have you ever had a serious medical problem? □ Yes □ No
If yes, please list (e.g. high blood pressure, diabetes, high cholesterol etc…)

_____

Family History Please list family medical history (e.g. cancer, heart disease, anemia, diabetes etc…)

Work History Occupation: _____ □ Retired □ Disabled □ Other _____

Are you: □ Single □ Married □ Partner □ Separated/Divorced □ Widowed

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New Patient Registration

PLEASE PRINT

Last Name of Patient	First Name	MI	M F	Age
Address	City	State	Zip	
Home Phone ( )	Cell Phone ( )	Date of Birth	Social Security No.	
Your Email address:				
Please sign _____ Date _____				

Please circle the Qualified medical condition that you have.

- Cancer
- Epilepsy
- Glaucoma
- Positive status for human immunodeficiency virus
- Acquired immune deficiency syndrome
- **Post-traumatic stress disorder**
- Amyotrophic lateral sclerosis
- Crohn's disease
- Parkinson's disease
- Multiple sclerosis
- **Medical conditions of the same kind or class as or comparable to those enumerated above**
- A terminal condition diagnosed by a physician other than the qualified physician issuing the physician certification
- **Chronic nonmalignant pain**