LRI Medical, LLC

Health History

Patient Name: _____ **Date of Birth:** _____

Accompanying Person: _____ **Relation:** _____

Reason for visit: _____

Please answer ALL questions to the best of your ability. If you are unsure of the answer, leave it blank.

Medications/Herbal Remedies or Vitamins: (name, dosage and directions-please be specific-you can attach a separate list)

_____ _____

_____ _____

_____ _____

Medical History: (please circle Yes or No, if **YES** specify when diagnosed)

Asthma/Lung Disease	Yes / No	High Blood Pressure	Yes / No
Bleeding/Clotting Disorder	Yes / No	High Cholesterol	Yes / No
Cancer	Yes / No	Kidney Disease	Yes / No
Diabetes	Yes / No	Liver Disease	Yes / No
Psychological Disorder	Yes / No	Anxiety	Yes / No
Depression	Yes / No	Stroke	Yes / No
Glandular Disorder	Yes / No	Tuberculosis	Yes / No
Heart Disease	Yes / No	Other _____	

Allergies: Yes or No Known Drug Allergies (if **YES**, please specify below)

Medication/Dosage/Reaction:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgical History: (what type of surgery and when)

_____ _____

_____ _____

Hospitalizations: (which hospital, when and the reason for admission/ER visit)

_____ _____

_____ _____

If over 65, have you fallen in the past year? If so, what caused the fall(s) (such as dizziness, related to medication, low blood sugar, tripped, etc.)?

_____

_____

For diabetic patients only:

How often do you check your blood sugar? _____

When did you last have A1C blood test & what was the results? _____

Specialists: (name of physician and condition treated)

_____

Patient/Guardian Signature: _____ **Date:** _____

Family History:

	Living Yes / No	Diabetes	High BP	Heart Attack	Heart Disease	Lung Cancer	High Cholesterol	Asthma
Mother								
Father								
		Breast Cancer	Ovarian Cancer	Uterine Cancer	Colon Cancer	Osteoporosis	Other	
All Family								

Social History:

Tobacco: Have you ever smoked? No / Yes Do you still smoke? No / Yes, how many packs per day / week? _____ How long did you smoke? _____years
Year you quit smoking? _____

Do you drink alcohol? No / Yes, how much per day / week? _____

Drug Use (illicit or non-prescribed) No / Yes, what type? _____ How often? _____ per day / week

Do you exercise? No / Yes, what type? Walking Running Weightlifting Biking Active

Type of diet on: _____

Caffeine (drinks or caffeine-containing drugs) No / Yes, how much? _____ cup(s) per day / week

Do you work? No / Yes, Part-Time / Full-time / Temporary / Volunteer

Preventative Medicine: (list last date of completion if applicable)

Bone Density _____ Flu Vaccine _____ Pneumovax _____

COVID vaccine Moderna / Pfizer / Johnson & Johnson / Astra Zeneca 1st / 2nd Dose Date _____

During the past 4 weeks, have you accomplished less than you would like with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

No, none of the time. Yes, a little of the time. Yes, some of the time.

Yes, most of the time. Yes, all of the time.

During the past 4 weeks, were you not as careful at work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

No, none of the time. Yes, a little of the time. Yes, some of the time.

Yes, most of the time. Yes, all of the time.

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all. A little bit. Moderately. Quite a bit. Extremely.

How much time during the past 4 weeks have you felt calm and peaceful?

All of the time. Most of the time. A good bit of the time. Some of the time.

A little of the time. None of the time.

How much time during the past 4 weeks did you have a lot of energy?

All of the time. Most of the time. A good bit of the time. Some of the time.

A little of the time. None of the time.

How much time during the past 4 weeks have you felt downhearted and blue?

All of the time. Most of the time. A good bit of the time. Some of the time.

A little of the time. None of the time.

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time. Most of the time. A good bit of the time. Some of the time.

A little of the time. None of the time.

Compared to one year ago, how would you rate your physical health in general now?

Much better. Slightly better. About the same. Slightly worse. Much worse.

Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed or irritable) now?

Much better Slightly better About the same Slightly worse Much worse.

LRI Medical, LLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First) _____(MI)_____

Address:_____

City, State, Zip:_____

Home Phone Number:_____ _____Cell: _____Work:_____

Date of Birth:_____E-Mail Address:_____

Patient Social Security Number: _____

Gender Identity: □ Female □Male □ Transgender □Choose not to disclose □ other _____

Race: □Black/African American □Hispanic □White □ Choose not to disclose □ other _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □Choose not to disclose

Preferred Language: □English □Spanish □ French □Other not listed_____

Marital Status: □Married □Single □Divorced □Widowed □Legally Separated □Partner □Other_____

Employment Status: □Full-Time □Part-Time □Not Employed □Self-Employed □Retired □Other_____

PHARMACY NAME & LOCATION: _____

Do you have a living will? □Yes □No

RESPONSIBLE PARTY INFORMATION (If not self) :

□Check here if address and telephone information is same as patient

Responsible party name: (Last)_____ (First)_____ (MI)____

Date of birth: MM___ /DD___ /YYYY____ Sex: □Female □Male

□Other_____

Responsible Party Social Security Number: _____ Phone number:_____

Address: _____City:_____ State:___ ZIP:_____

EMERGENCY CONTACT INFORMATION:

Emergency contact name: (Last)_____ (First)_____

Phone number:_____ Emergency contact relationship to patient:_____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT:

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____

Printed name_____ **Date:**_____

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other West Florida Medical providers may be made available to subsequent West Florida Medical provider to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, LRI MEDICAL, LLC may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge LRI MEDICAL, LLC may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to LRI MEDICAL, LLC any insurance or other third-party benefits available for health care services provided to me. I understand LRI MEDICAL, LLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to LRI MEDICAL, LLC, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to LRI MEDICAL, LLC by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for LRI MEDICAL, LLC, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that LRI MEDICAL, LLC or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or LRI MEDICAL, LLC or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

West Florida Medical Associates PA
LRI Medical LLC
Catherine Sembrano Navarro, MD
Yelandra Daniels, MD
Carrie Staton, APRN

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

Address: _____ City/St/Zip: _____

Patient authorizes the following provider/facility to disclose information described below, for the purpose of continued medical care:

Provider/Facility: _____ Fax: _____

Address: _____ City/St/Zip: _____

( ) Office Notes ( ) Diagnostic Reports ( ) Consults

( ) Lab Results ( ) Other :_____

This information may be disclosed to and used by: West Florida Medical Associates PA
LRI Medical LLC
352-794-3843

Authorization shall expire (1) year from the date of signature unless otherwise noted here:

_____.I

MPORTANT: By signing below, patient understands that this Authorization for Release of Medical Records shall include records dated prior to and including the date of this Authorization. Patient understands that this Authorization is voluntary and patient may refuse to sign. If patient refuses to sign, the refusal will not affect patient's ability to obtain treatment from the Practice. Patient understands that this Authorization may be revoked at any time by notifying the Practice's Privacy Officer. However, revocation shall not be valid to the extent the Practice has taken action in reliance on this Authorization, or to the extent this Authorization is executed as a condition for obtaining insurance coverage. Patient understands that the Practice shall not condition treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether patient provides Authorization for the requested use or disclosure.

_____ _____

Patient/Authorized Representative Signature Date

756 N Suncoast Blvd
Crystal River, FL 34429
Phone: (352) 228-4984
Fax: (352) 794-3843

West Florida Medical Associates PA
LRI Medical LLC
Catherine Sembrano Navarro, MD
Yelandra Daniels, MD
Carrie Staton, APRN

RX HISTORY CONSENT FORM

I, _____, give my permission for LRI Medical LLC to e-scribe or fax my prescriptions to my pharmacy; and to ask my pharmacy for my prescription history.

Patient Signature: _____ Date: _____

Please list the other doctors/specialists you have seen in in the past

Name	Specialty

756 N Suncoast Blvd
Crystal River, FL 34429
Phone: (352) 228-4984
Fax: (352) 794-3843