MED LIFE FIT
MEDICAL CLINIC & SPA

Med-Life-Fit Patient Demographic Form

PLEASE PRINT

Patient Name (Last, First, M.): _____
Patient Date of Birth: _____/_____/_____

Patient Social Security #: _____

Guardian Name (if Minor) _____

Guardian Date of Birth: _____/_____/_____

Guardian Social Security #: _____

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

_____

_____

City State Zip

Primary Phone: (_____) _____-_____ Cell Phone: (____) _____-_____

E-mail address: _____@ _____

Employer: _____ Employer Phone: (_____) _____-_____

Employer Address: _____

Street City State Zip

Primary Care Provider: _____ Referring Provider: _____

Pharmacy/Address/Phone: _____

Check One	
Sex	☐ Male ☐ Female
Race (Select One)	☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Declined
Ethnicity (please check)	☐ Hispanic/Latino ☐ Non-Hispanic ☐ Declined

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _(____)_____-_____

WORKMANS' COMPENSATION / MVA / LITIGATION

Is this a ☐ work related injury? ☐ MVA? ☐ Accident? ☐ No ☐ Yes Date of Injury: _____

Adjuster Name: _____ Adjuster Phone: _____

Do you have an attorney? ☐ No ☐ Yes

Attorney Name: _____ Attorney Phone: _____

INSURANCE

	Primary	Secondary
Name of Company		
I.D./Policy Number/Claim #		
Group Number		
Policy Holder Name		
Address (If different from patient)		
Policy Holder Date of Birth	/ /	/ /
Policy Holder Social Security #		

PATIENT RECORD OF DISCLOSURES

I give my permission to discuss my personal history information (test results, med changes, etc.) with the following persons:	Name	Relationship

Signature Date

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Patient Information Sheet

CONSENT FOR TREATMENT:

I voluntarily consent to care involving diagnostic tests, procedures and medical treatment as ordered by the physician and his/her assistants or designees. I voluntarily consent to the allied health students observing and participating in my care under the supervision of a qualified professional. My physician may also request the services of an outside technical consultant regarding equipment, etc., that is utilized in my care and I voluntarily consent to such treatment and procedures. No guarantee has been given to me as to the results that may be obtained from my care.

PROFESSIONAL CARE:

The physicians and allied health care providers involved in my care may or may not be employees of Med-Life-Fit Family Practice and in some instances may be independent contractors and practitioners. Other healthcare providers such as consulting physicians, surgeons, emergency department physicians, radiologists, pathologists, physician assistants and others are independent contractors and practitioners and are not agents, servants or employees of Center for Medical Weight Loss. Charges established by those practitioners will be billed to you separately.

PERSONAL VALUABLES:

Med-Life-Fit Family Practice shall not be liable for the loss of or damage to any money, jewelry, glasses, contact lenses, dentures, documents, or other articles of unusual value.

SMOKE-FREE ENVIRONMENT:

Med-Life-Fit Family Practice maintains a smoke-free environment on its campus and in all of its facilities; therefore smoking is prohibited. Med-Life-Fit Family Practice advises that there are health risks associated with smoking and encourages everyone to stop smoking for life.

CONSENT TO PHOTOGRAPHY:

I understand that photographs, digital or other images may be used to document my care, provide treatment, or carry out healthcare operations, and I hereby consent to such activities. I understand that Med-Life-Fit Family Practice will retain ownership rights to all photographs, digital or other images but that I will be allowed access to any photographs or images and be allowed to obtain copies. I understand that these images will be stored in a secure manner as part of my medical record and may be used and disclosed as described in Center for Medical Weight Loss's Notice of Privacy Practices.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:

I certify that the information given by me is correct and accept full responsibility for all charges associated with the care provided, including those services as stated above. Payment of any portion of my bill not covered by a third party payer is due at time of service unless Med-Life-Fit Family Practice has agreed to other arrangements. I agree to the assignment of all third party benefits to Med-Life-Fit Family Practice and to any independent practitioners for all charges for services which are not covered or paid by the third party payer regardless of the reason, including but not limited to a determination by any third party payer that such services are not covered services or medically necessary. After reasonable notice, any unpaid account may be turned over to a collection agency and/or attorney for collection. Should it be necessary for the medical provider to pursue collection, I agree to pay all reasonable collection costs, including court costs and attorney's fees incurred in collecting my account. If I am signing as a Med-Life-Fit Family Practice patient, I acknowledge that there may be a $35.00 charge for any appointment not cancelled within twenty-four (24) hours. I also understand that this fee must be paid in full on or before my next office visit.

AIDS/PATIENT'S RIGHTS AND RESPONSIBILITIES/PRIVACY NOTICE:

By signing below, I acknowledge I have been offered an AIDS brochure, Patient's Rights & Responsibilities & Med-Life-Fit Family Practice' Notice of Privacy Practices either today or previously.

MEDICARE PATIENTS:

I authorize the release of any medical or other information necessary to process my Medicare claim. I also request the payment of government benefits to be made to Med-Life-Fit Family Practice, LLC who accepts assignment. I understand that I am responsible for the deductible and coinsurance amounts and non-covered services.

Please mark one of the following ☐ Medicare is my primary insurance. ☐ Medicare is my secondary insurance because

☐ I am still actively employed

☐ My spouse is still actively employed

☐ End Stage Renal Disease

☐ Other _____

MEDIGAP BENEFITS:

I request payment of Medigap from _____be paid to Med-Life-Fit Family Practice for services which have been furnished to me. I authorize release of any information needed to determine these benefits.

Signature: _____ Date: _____

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1) **PATIENT INFORMATION:**

Name		Date of Birth		Previous Name
				( )
Address	City	State	Zip	Daytime Phone

2) **AUTHORIZES:**

Name of Health Care Provider/Plan/Other				
				( )
Address	City	State	Zip	Phone

3) **TO DISCLOSE TO:**

☐ Self, Delivery Options: ☐ Pick up: ☐ View on Site ☐ Mail to address above

☐To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to ☐ Jessica Dowe, M.D., 10512 Meeting Street, Suite 101, Prospect, KY 40059
Fax: 502-354-7228

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ to _____.
If left blank, only information from the past two (2) years will be disclosed. (month/year) (month/year)

5) **INFORMATION TO BE DISCLOSED:**

☐ All medical records related to (specify condition, treatment, etc.): _____

☐ All billing records related to (specify condition, treatment, etc.): _____

☐ Radiology films/images (specify test): _____

☐ Specific records/information as follows: _____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

6) **EXPIRATION:** This Authorization is good until the following date/event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE:** (Check all that apply–**copy fees may apply)**☐ Further Medical Care ☐ Legal Investigation/Action

☐ Insurance Eligibility/Benefits ☐ Personal (at my request) ☐ Other: _____

8) **YOUR RIGHTS WITH REAPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. A also am aware that I may revoke this Authorization by notifying the disclosed medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **SIGNATURE OF PATIENT/LEGAL REP:** _____ **DATE:** _____
If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ Legally incompetent or incapacitated ☐ deceased

2. Legal authority: ☐ a parent ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

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Communications Preference Form

Notice to patients: Use this form to make a request to MLF that we communicate with you by the alternative means or locations.

In order for MLF to respond promptly and accurately to your request, please complete this form entirely.

Patient Name _____ Date of Birth _____

Primary contact number (_____)_____ Secondary contact number (_____)_____

Address _____
City State Zip

Email _____
Home Work

By giving us your email address you are giving Med Life Fit permission to send you digital communication.

How would you prefer to communicate with MLF? Check and number for all that apply

Yes	No		Yes	No	
____	____	Phone – Primary	____	____	Email address
____	____	Phone – Primary	____	____	US Mail (home address

Where can we leave a message or an appointment reminder?

____ ____ Phone – Primary

____ ____ Phone – Secondary

Please initial the following

_____ I understand that some sensitive information (HIV, STD, abnormal lab results and diagnoses) will not be left as a message nor be discussed over the phone.

_____ I understand that I will have to fill out a PATIENT PROXY/REPRESENTATIVE form to authorize another person to communicate with the practice on my behalf.

_____ I have reviewed and I understand this form.

Patient Signature _____ Date _____

For Personal Representative of the Patient (If applicable):_____

Print Name of Representative _____

Relation to Patient _____

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Patient Representative _____ Date _____

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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize Family Practice to use and disclose a copy of the specific health and medical information described below.

Name of Patient: _____
DOB/SSN: _____

Description of information on above named patient to be used disclosed:
_____
_____
_____

Name of Recipient: _____

Purpose of Disclosure: _____
_____
_____

If Family Practice requests this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:
1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this authorization, and
4. We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed o complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law.

By: _____ Date:_____
(Patient)

Or By: _____ Date: _____
(Patient's Representative)

Description of Representative's Authority _____
_____
_____

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Patient Representative Authorization/Proxy Form

This form allows you to choose a patient representative (a designated person authorized by you) that allows Med-Life-Fit Family Practice to disclose/share your medical Information. (Example: Spouse, Parent, Family member, or any person of your choice) You may place limitations on the type of information that is to be disclosed, or choose not to select a representative.

- PATIENT NAME: _____
  (Please print clearly)
- PATIENT DOB: _____

Please check one:

☐ **I DO NOT wish to select a patient representative at this time.**

☐ **I DO wish to select a patient representative at this time.**

I _____ designate _____
(State relationship to patient) _____ as my representative. My signature below acknowledges that I give my authorization for Family Practice to disclose any and all medical information pertaining to my care to the above named representative.

***Please indicate any restrictions/limitations of medical information to be shared with your representative:**

_____
_____
_____
_____
_____

My designated representative can be reached:
Phone (Home) _____ Work _____

__ I have reviewed and I understand this form.
__ I understand that I can withdraw my consent in writing at any time.

Patient Signature: _____ Date: _____