Today's date _____ Prior Physician _____

Who referred you to us? _____ Phone #: _____

Patient's Name _____ DOB _____ Age_____

Mailing Address_____

_____ Sex: Male ___ Female ___ Social Security # _____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Pharmacy Name: _____ Pharmacy Phone # _____

Has any member of your immediate family been treated by us before? _____

Who is financially responsible for this bill? _____ Employer: _____

Employer Address _____Phone # _____ Occupation _____

Driver's License #_____ DOB _____ Social Security # _____

Insurance Company _____ Policy #_____

Group # _____ Insurance Claims Address _____

Secondary Insurance _____ Policy #_____

Group # _____ Insurance Claims Address _____

Marital Status _____ Spouse DOB _____ Spouse SS # _____

Spouse Name _____ Employer _____ Phone #: _____

Insurance Company _____ Policy #_____

Group #_____ Insurance Claims Address _____

Emergency Contact Name _____Relationship_____ Phone #: _____

Emergency Contact Name _____Relationship_____ Phone #: _____

WE WELCOME YOU!

We realize that time is as important to you as it is to us. We adhere to our appointment schedule as closely as possible. However, due to the unpredictable nature of medical care, unexpected delays may occur. We trust that you will understand.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGMENT OF BENEFITS

I hereby authorize the release of any medical information required in the course of my treatment necessary to process insurance claims. I also, authorize payment of health benefits to Live Better Health Center for health services rendered in the course of my treatment. I understand that I am personally responsible for payment in full for all expenses incurred for services rendered.

PATIENT SIGNATURE: _____

I authorize discussion of my general health condition and diagnosis (including treatment, payment and healthcare operations) with: ( ) spouse ( ) Children ( ) Other
Name(s): _____

Please list the family members or significant others, if any, whom we may inform about your medical condition. ONLY IF AN EMERGENCY:
Name: _____ Phone #: _____
Name: _____ Phone #: _____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked, "CONFIDENTIAL" ( ) YES ( ) NO

I authorize the pick-up of my health records/prescriptions/test results by:
( ) spouse ( ) Children ( ) Other
Name(s): _____
Please print the telephone number and/or email address where you want to receive messages about your appointments, lab, and X-ray results, or other health information; phone number: _____,
and an email address if you prefer to communicate via email:_____

I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE

Can confidential messages (i.e. appointment reminders) be left by voicemail? ( ) YES ( ) NO

text? ( ) YES ( ) NO email? ( ) YES ( ) NO

This authorization is only valid for the person(s) I have listed above.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____
(Staff employee)

COMPREHENSIVE HEALTH HISTORY

This important information is confidential. No one other than your healthcare provider will have access to knowledge of this information without written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the best health care possible. This form will be reviewed with you during your visit.

General

Name:		DOB:	SS#
Date of your last complete exam?		Date of your last chest X-ray?	
Date of your last cholesterol screening?		Date of your last dental exam?	
Date of your last eye exam?		Date of your last colonoscopy?	
Women		**Men**	
Date of your last mammogram?		Date of your last PSA?	
Date of your last pap smear?		Date of your last rectal/prostate exam?	

Immunizations

Measles - Mumps - rubella (MMR)	Date:	Pneumonia	Date:
Tetanus and diphtheria toxoids (TD)	Date:	Hepatitis B	Date:
		Influenza	Date:

Past Medical History: (check those that apply)

☐ AIDS or HIV+	☐ Chicken Pox	☐ Measles	☐ Rheumatic Fever
☐ Blood or Plasma Transfusions	☐ Epilepsy	☐ Mumps	☐ Scarlet Fever
☐ Cancer	☐ Infectious Mononucleosis	☐ Polio	☐ Whooping Cough

Hospital/Surgical History

Illness or Operation	Date	Illness or Operation	Date
1)		4)	
2)		5)	
3)		6)	

Allergies

Please list any drug, food, contact, or environmental substances to which you had an allergic or bad reaction.

Medications

Please list any prescription medications, over the counter medications, vitamins, herbs, or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.

1)	4)	7)
2)	5)	8)
3)	6)	9)

Social History

Occupation:				Marital Status:				
Do you exercise regularly?	YES	NO	What type?		How often?			
Do you smoke?	YES	NO	I currently smoke packs per day.		I have smoked for years.			
I formerly smoked but stopped in: (List yr)			Do you wear seat belts?	YES NO	Do you drink alcohol?	YES	NO	
Do you use other forms of tobacco?	YES	NO	Do you use ilicit drugs?	YES NO	How often/how much			
How often/how much			How often/how much					
Do you have any risks factors for HIV infection?	YES	NO	Have you ever been exposed to anyone with tuberculosis?			YES	NO	
Have you had excessive exposure to the sun because your work or recreation?						YES	NO	
Are you currently experiencing unusual stress?	YES	NO	Explain:					
Are there any environmental risks involved in your job or home environment?	YES	NO	Explain:					

Family History

	Relationship		Relationship		Relationship
☐	Anemia	☐ Epilepsy		☐ High cholesterol	
☐	Asthma	☐ Glaucoma		☐ Kidney disease	
☐	Obesity	☐ Leukemia		☐ Thyroid disease	
☐	Cancer	☐ Depression		☐ High Blood Pressure	
☐	Diabetes	☐ Heart disease		☐ Alcohol problems	
☐	Stroke	☐ Lung disease		☐ Bleeding tendency	

Present Age or Age of Death

Mother:		Father:
Sibling #1	Sibling #2	Sibling #3

Women Only

Menstrual Period Onset:	Regular?	YES	NO	Date of last period began:
Age at menopause:	Difficulty w/ periods?	YES	NO	Specify:

Pregnancies/No. of children:	Born alive:	Cesarean:	Premature:	Stillborn:	Miscarriages:
Describe complications:					

Do you have any pending medical procedures? _____

If any pending medical procedures, please explain: _____

_____

_____

Live Better HEALTH CENTER

Live Better MEDICAL GROUP

PLEASE CIRCLE EACH CURRENT SYMPTOM YOU HAVE

General Questions
Weight loss
Weight gain
Change in sleep patterns
Change in activity capacity

Neurological and Psychiatric
Anxiety
Headaches
Depression
Meningitis
Paralysis
Seizure
Stroke
Tingling
Tremors
Memory Loss
Faiting spells, dizziness
Head injuries
Blackouts or near blackouts
Change in sensation anywhere on your body
Localized weakness or numbness

Ears, Eyes, Nose and Throat
Hay fever
Glaucoma
Polyps
Allergy
Cataracts
Goiter
Hoarseness
Double vision
Gum problems
Eye problems
Ear infections
Glasses/contacts
Ear discharge/pain
Frequent nosebleeds
Ringing in your ears
Sinus infection
Swollen glands

Cardiovascular
Angina
Leg cramps
Ankle swelling
Awakening at night short or breath & getting out of bed
Cardiac catherization
Cold hands or feet
Congenital heart defects
Dizziness when standing up quickly
Heart attacks
Heart failure
High or low blood pressure
Irregular heart rate
Purple fingers or lips
Leg pain that resolves w rest
Heart palpitations
Varicose veins
Chest pain
Murmurs

Respiratory
Pleurisy
Asthma
Breathlessness lying flat
Prolonged cough
Coughing up blood
Emphysema
Shortness of breath
Tuberculosis
Pneumonia
Frequent Infections (bronq.)
Wheezing

Skin
Abscess
Acne
Boils
Hives
Lumps
Jaundice
Athletes foot
Excessive body odor
Excessive sweating
Fungal infections
Nail problems
Moles - irregular - change - new
Dandruff
Oily skin
Rashes
Dry skin
Psoriasis

Kidney & Urinary Tract
Blood in urine
Brown in urine
Dribbling after urination
Painful urination
Excessive thirst
Involuntary urination/ incontinence
Urinating frequently (day)
Urinating frequently (night)
Urine hesitancy
Weak flow
Frequent bladder infections
Kidney disease
Kidney stone

Endocrine
Diabetes
Abnormal body hair
Changes in skin texture
Cold intolerance
Heat intolerance
History of "borderline" diabetes
Increased loss of hair
Rheumatism
Thyroid disease
Sickle cell

Male & Female
Painful sexual intercourse
Loss of sexual interest
Unprotected sex
Groin itching
Sexually transmitted diseases

Males only
Hernia
Bloody ejaculation
Inability to complete intercourse
Lump on testicle
Penile discharge
Premature ejaculation
Problems maintaining or keeping an erection
Prostate disease
Sores on penis or warts
Testicular pain
Testicular swelling
Sterility

Musculoskeletal
Anemia
Back pain
Gout
Neck pain
Abnormal blood counts
Blood clots in legs/lungs
Bone marrow biopsy
Easy bleeding
Easy bruising
Joint swelling
Morning stiffness
Muscle aches
Arthritis
Bursitis
Joint aches
Tendonitis

Gastrointestinal
Diarrhea
Reflux
Ulcers
Hepatitis
Abdominal pain
Anal fissures
Black tarry stools
Vomiting blood
Constipation
Nausea
Problems swallowing
Hiatal hernia
Intestinal Obstruction
Liver disease
Hemorrhoids
Red blood after bowel movements
Gallstones
Vomiting
Heartburn
Indigestion

Female only
D+C
Hernia
Abn. bleeding between cycles
Abnormal pap smear
Bleeding after intercourse
Complication w/ pregnancy
PMS
Endometriosis
Heavy bleeding during cycles
Discharge from breast
Ovarian cysts
Pelvic inflammatory disease
Postmenopausal symptoms
Vaginal discharge
Vaginal dryness
Vaginal warts
Hot flashes

Provider notes_____

_____

_____

_____

_____

_____

Wellness Center
4441 Park Blvd. N.,
Pinellas Park, FL 33781

Live Better Pharmacy
4421 Park Blvd. N.,
Pinellas Park, FL 33781

Clearwater
1831 N. Belcher Rd., Ste E-1,
Clearwater, FL 33765

Pinellas Park
4423 Park Blvd. N.
Pinellas Park Fl. 33781

727.827.2825
info@livebetterhc.com
www.livebettermedicalgroup.com

FINANCIAL POLICY

As your healthcare provider, we are committed to providing you with the best possible health care. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment is due at time services are rendered: We accept cash, credit card and care credit.

Cancelled appointments: If you need to cancel or reschedule an appointment, particularly a well visit or consultation, please do so at least 24 hours in advance. A significant amount of time is allotted for these appointments and we would like to offer this time to other patients if you are unable to keep your appointment. There is a $35 fee for routine appointments missed or cancelled with less than 24 hours' notice.

Contracted coverage: Co-payments and deductible must be paid at the time of service. Because we are providers with insurance companies, we will file your insurance claim directly.

Medi care: You are responsible for your annual deductible and 20% of the allowable charges due at the time of service, unless you have supplementary insurance.
Please bring your Medicare Explanation of Benefits (EOB) showing that you have met your deductible.

HMO/MCO: If you are required to select a PCP by your insurance carrier, then you must change your PCP prior to scheduling an appointment with our office. If this is not done and your insurance carrier declines payment you will be responsible for the office visit in full based on our fee schedule.

Financial Agreement: We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. However, you must realize that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover.

We must emphasize that as your health care provider, our relationship and concern is with you and your health, not your insurance company.

All charges are your responsibility from the date services are rendered.

Any balance on your account after 90 days, including those that insurance has not paid, may result in a collection action. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our billing staff promptly for assistance in the management of your account. We are willing to work with you on setting up a payment plan.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.
If you have any questions about the above referenced information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the above financial policy.

Patient's Signature _____ Date _____

PATIE NT'S BILL OF RIGHTS AND RESPONSI BILITIES

Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and respect that healthcare provider's or healthcare facility's right to expect certain behavior on the part of patients. You may request a copy of full text of this law from your healthcare provider or facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection need for privacy.
A patient has the right to a prompt and reasonable response to questions and requests.
A patient has the right to know who is providing medical services and who is responsible for his or her care.
A patient has the right to know what support services are available, including whether an interpreter is available if he or she doesn't speak English or Spanish.
A patient has the right to know what rules and regulations apply to his or her conduct.
A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternative, risks, and prognosis.
A patient has the right to refuse any treatment, except as otherwise provided by law.
A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources to his or her care.
A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or facility accepts the Medicare assignment rate.
A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
A patient has the right to receive a copy of reasonable clear and understandable, itemized bill, and upon request, to have the charges explained.
A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the healthcare provider of facility in which served him or her and to the appropriate state licensing agency.
A patient is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information and present complaints, past illnesses, hospitalizations, medications, and other matter relating to his or her health.
A patient is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
A patient is responsible for reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
A patient is responsible for following the treatment plan recommended by the healthcare provider.
A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the healthcare provider or facility.
A patient is responsible for his or her actions if he or she refuses treatments or does not follow the healthcare provider's instructions.
A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
A patient is responsible for following the healthcare facility rules and regulations affecting patient care and conduct.

Patient's Signature _____ Date _____

HIPAA PRIVACY NOTICE

The misuse of individually identifiable health information (PHI) has been identified as a national problem causing patient inconvenience, aggravation and money. We want you to know that all of our employees, managers and nurses continually undergo training so that they may understand and comply with government rules and regulations regards the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with particular emphasis on the privacy rule.

It is our policy to properly determine appropriate use of PHI in accordance with governmental rules, laws and regulations. We want to ensure that we do not participate in the improper disclosure of PHI. As part of this plan we have implemented a compliance program that we believe will help us prevent any inappropriate use of PHI. Our company is dedicated to maintaining the privacy of your PHI. This notice is effective April 14, 2003.

USE AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

We will use and disclose your PHI in the following ways:
Except as explained below, we will not use your PHI for any purpose unless you have signed a form authorizing a use or disclosure. The specific policy regarding the authorization is detailed later in the section of this document regarding your rights.

1. **Treatment:** In order to best address your health your health care needs we will use information in your medical records with all treatments and/or services documented in your medical records. PHI may be disclosed to other health care professional outside of **Live Better Health Center, LLC.** who are directly or indirectly involved in your care.
2. **Payment:** We will use and disclose your PHI as necessary to bill and collect payment for services and items rendered by us to you. Recipients of this disclosure could include, but may not be limited to: insurance companies, other family members who are responsible for paying your bill, those identified as having power of attorney.
3. **Health Care Operations:** We will use your PHI as necessary for health care operations. The evaluation of care received, cost-management and business planning activities, quality assessment, quality improvement, medical reviews and compliance issues are some examples of health care operations. This listing would not be considered to an all-inclusive listing of health care operations.
4. **Appointments and Reminders:** We may need to remind you of medical appointments or follow ups for certain treatments.
5. **Non-Medical Communications:** We may send you a birthday card, a holiday card or perhaps a newsletter.
6. **Release of Information to Family/Friends:** We may release PHI to a friend or family member that is involved in your care or who assists in taking care of you. This disclosure will only be such that is relevant to their involvement with your care of paying for your care.
7. **Other Disclosure required by Law:** In certain circumstances we may be required by federal, state or local law to disclose PHI.
8. **Business Associates:** Certain aspects and components of our services are performed by independent contractors, outside people or organizations pursuant to agreements or contracts. It will be necessary for us to disclose PHI to those contractors, outside people or organizations that performed services on our behalf. We require Business Associates to properly and appropriately safeguard the privacy of PHI.

YOU HAVE CERTAIN RIGHTS REGARDING YOUR PHI. THESE INCLUDE THE FOLLOWING:

Confidential Communication: You have the right to request that our company communicates with you about your health and related issues in a particular manner or location. For instance you may request that we call you at home rather than at work. Such request must be in writing and must be directed to the **HIPPA Privacy Officer, Live Better Health Center, LLC. 4423 Park Blvd., Pinellas Park FL 33781.** We will accommodate reasonable request. You do not have to give a reason for your request.

Restrictions: You have the right to request a restriction in the use of your PHI for TPO. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by Law, in emergencies or when the information is necessary in order to treat you. In order to Request a restriction in our use or disclosure your PHI you must make your request in writing to the **HIPPA Privacy Officer, Live Better Health Center, LLC. 4423 Park Blvd., Pinellas Park FL 33781.** Each request must describe in clear and concise manner:

The information you wish restricted:

Whether you are requesting to use our company's use, disclosure or both: To whom you want the limits to apply.
Inspection and Copies of Records: You have a right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including medical and billing records. A fee may be charged for copies and associated labor and an appointment must be set up in order for you to inspect your PHI. A request to inspect your PHI must be made in writing to the **HIPPA Privacy Officer, Live Better Health Center, LLC. 4423 Park Blvd., Pinellas Park FL 33781.**

Amendments: You may ask us to amend your PHI if you believe it to be incorrect. Any request for treatment must be made in writing to the **HIPPA Privacy Officer, Live Better Health Center, LLC. 4423 Park Blvd., Pinellas Park FL 33781.** You must provide us with a reason in writing supporting your request for amendment.

We may deny your request if it is our opinion that the PHI is inaccurate and incomplete or not part of the PHI created by our company.

HIPAA PRIVACY NOTICE

Accounting of Disclosure: You have the right to an accounting of disclosure for non-routing disclosure of PHI. Non-routing disclosures of PHI would de disclosures made for non-treatment, non-payment or non- operations purposes. All requests for disclosure accounting must be in writing to the **HIPPA Privacy Officer, Live Better Health Center, LLC. 4423 Park Blvd., Pinellas Park FL 33781.** All such request must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before. Copy and labor charges may apply. It is our policy not to disclose PHI for any purpose other than TPO.

Right to a Paper Copy of This Notice: You may request a paper copy of this notice at any time.

Right to file a Complaint: If you believe your privacy rights have been violated you may a complaint with our company or with the Secretary of the Department of Health and Human Services, to file a complaint with our company contact the **HIPPA Privacy Officer, Live Better Health Center, LLC. 4423 Park Blvd., Pinellas Park FL 33781.** You will not be penalized for filling a complaint.

Right to Provide an Authorization for other Uses and Disclosures: Our Company will obtain you writing consent for use and disclosures that are not permitted by applicable law. Any authorization you provide us regarding the use and disclosure of your PHI may be revoke an action already in progress or completed which was based upon a previous authorization. A revocation must also be in writing and directed to
HIPPA Privacy Officer, Live Better Health Center, LLC. 4423 Park Blvd., Pinellas Park FL 33781.

Your signature authorizes removal of chart record for internal review by staff physician(s).

PATIENT'S SIGNATURE	DATE

AUTHORIZATION FOR USE OR DISCLOSURE OF INFO

I,_____, hereby authorize

_____

(Name of Physician or Group Practice requesting medical information from)

_____ To disclosure the following protected health information outlined below to:

Live Better Health Center : 4423 Park Blvd., Pinellas Park, FL 33781- Phone: 727-827-2825, Fax: 727-827-2809

Description of records requested: _____

IF MORE THAN TEN PAGES PLEASE MAIL

This protected health information is being used or disclosed for the following purposes: _____

This authorization shall be in force and effect for one year from _____ (Date)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Live Better Health Center : 4423 Park Blvd., Pinellas Park, FL 33781.

I understand that a revocation is not effective to the extent that _____ (Provider requesting records from) has relied on the use of disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Live Better Health Center , will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provider authorization for the requested use or disclosure.

I understand that I have the right to:

- ☒ Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to Live Better Health Center , from a third party. (If applicable)

_____ DOB: _____

Signature of Patient or Personal Representative

_____ Date: _____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3: with 0 meaning you would never *doze or fall asleep* in a given situation; and 3 meaning that there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you mark a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE: _____

Patient Name: _____ Date: _____