LISTER HEALTHCARE DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

NAME: ______________________ DOB: ____________ SSN: ____________________

MAILING ADDRESS: ____

PHONE: ______________ CELL: ______________ EMAIL: ____________________

MARITAL STAUS: Single Married Widowed Divorced SEX: ________ RACE: ________

EMPLOYER: ______________ WORK PHONE: ____________ OCCUPATION: __________

SPOUSE'S NAME: ________________ SPOUSE'S DOB: ____________

RESPONSIBLE PARTY

NAME: ____________________ RELATIONSHIP TO PATIENT: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE: __________ SUBSCRIBER: ________________ DOB: __________

CONTRACT ID: __________________ GROUP NUMBER: __________

SECONDARY INSURANCE: __________ SUBSCRIBER: ________________ DOB: __________

CONTRACT ID: __________________ GROUP NUMBER: __________

EMERGENCY CONTACT

NAME: ______________________ PHONE: ______________ RELATIONSHIP: __________

EXPLANTION OF PAYMENT POLICY/ INSURANCE FILING/ ELECTRONIC ACCESS

I hereby authorize Lister Healthcare to release any and all information acquired in my examination and treatment to my insurer. I will furnish the necessary insurance cards/forms and my signature to this office. I authorize Roy Barco, MD and Lister Healthcare staff to use electronic means to access my medical and insurance information. I hereby assign and authorize payment directly to Lister Healthcare of any medical and surgical benefits otherwise payable to me. Should an insurance payment be received that is less than the provider's usual charge for the service provided, I will be responsible for the difference. I also agree to pay all costs of collection, including but not limited to, reasonable attorney's fees, and waive all claims of exemption under Alabama law. I authorize treatment by Roy Barco, MD, Lister Healthcare, and personnel. This form must be signed and dated by the patient or responsible party.

PATIENT/ REPRESENTATIVE SIGNATURE: ________________________ **DATE:** __________

LISTER HEALTHCARE RELEASE OF INFORMATION

Authorization to Use/Disclose Health Information

Patient Name: ______________________________

Date of Birth: ____________________ SSN: ____________________

Signature: ______________________________ Date: __________

Witness: ______________________________

I authorize the use or disclosure of health information and/or records, including but not limited to:

- Last two (2) progress notes
- Most recent EKG
- Most recent DEXA, CT, MRI, GXT, Echo, and Mammogram reports
- Plain film x-ray reports (Within the last year)

Other: ______________________________

RELEASE FROM: ______________________________

Phone: ______________________________

Fax:______________________________

RELEASE TO:

___ Lister Healthcare
102 Physicians Drive, Ste. A
Muscle Shoals, AL 35661
Phone: 256-286-4026
Fax: 256-381-4783

___ Lister Healthcare
104 Physicians Drive, Ste. A
Muscle Shoals, AL 35661
Phone: 256-383-6070
Fax: 256-381-4022

CONSENT FOR INFORMATION RELEASE

I, ___________________________, hereby authorize Lister Healthcare to release any and all information acquired in my examination and treatment to:

NAME: ____ RELATIONSHIP: _________________________

NAME: ____ RELATIONSHIP: _________________________

NAME: ____ RELATIONSHIP: _________________________

Please check any additional authorizations that may apply:

______ Please DO NOT phone me at home.

______ Please DO NOT phone me at work.

______ Please DO NOT leave voicemail messages.

SIGNATURE: ____________________________________ DATE:__________________

Lister Healthcare Notice of Privacy Practices Acknowledgement

I acknowledge receipt of the Notice of Privacy Practices with detailed information regarding how Lister Healthcare may use and disclose my protected health information. I understand that Lister Healthcare reserve the right to change the privacy policy and that a copy of the revised notice will be made available to me.

NAME:_________________________ **SIGNATURE:**__________________________ DATE:________________

************OFFICE USE ONLY – DOCUMENTATION OF GOOD FAITH EFFORT************

The above patient was provided with a copy of the privacy practices. A good faith effort was made to obtain a written acknowledgement of receipt of the notice. However, the patient declined to sign.

EMPLOYEE SIGNATURE AND DATE:____

HOSPITAL ADMISSION POLICY

Dr. Barco can admit patients to NAMC Shoals Hospital. Please note: if you are admitted to NAMC/Florence, NAMC/Shoals, or Helen Keller Hospital, you will be seen by the hospitalist on staff.

I have read and understand the Hospital Admission as clearly stated above.

SIGNATURE: ________________________________ DATE:______________________

NO SHOW POLICY

To best serve our patients and help accommodate those that need a same-day appointment, it is important to know exactly which patients will be present on a given day for an appointment. Therefore, it is vital that patients keep their scheduled appointments. We understand that unforeseen circumstances can sometimes prevent you from keeping your appointment. We ask that you notify the office staff as soon as possible in this case. We can then reschedule your appointment and accommodate other patients that may need to be seen that day. Any patient who no shows an appointment or cancels an appointment within an hour of the appointment time will be assessed a $25 fee that must be paid before their next appointment. This is not covered by insurance and will be the responsibility of the patient. As well, 3 no shows in one year may result in being restricted to same day appointments or dismissal from the practice. We have instilled this policy to ensure that we can serve as many of our patients as possible.

I have read and understand the No Show policy as clearly stated above.

SIGNATURE: ________________________________ DATE:______________________

NARCOTIC POLICY FOR DR. ROY BARCO

Narcotic medications (such as Norco, Precocet, morphine, oxycodone, oxycontin, butrans, Dilaudid, Fentanyl, and methadone) are commonly used in the management of both acute (recently occurring) and chronic pain. However, over the past several years, there has been a growing problem with abuse, misuse, and diversion of narcotics. Unfortunately, it is increasingly difficult to know who is taking narcotics appropriately or not. Due to this, Dr. Barco has made the decision to NOT prescribe opioids for chronic pain. This does not mean that he will not treat your pain. He will use any non-narcotic means at his disposal to improve your pain and help pyour quality of life. If narcotic medication is needed to help with your pain, he will gladly refer you to a pain management specialist.

While Dr. Barco may use narcotic medicines to treat certain acute pain conditions (i.e. a bone fracture), he will only do so if there is clear clinical evidence that there is a medical cause of the acute pain and that there is no potential for narcotic misuse by the patient.

By signing, I certify that I have read and clearly understand Dr. Barco's narcotic policy.

SIGNATURE: ________________________________ DATE:______________________

Lister Healthcare Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

All patients must fill out our patient information forms and present insurance information prior to being seen. We will ask to see your insurance card and update your demographic information routinely to ensure our records are correct.

MINOR PATIENTS: Parents are financially responsible for care rendered to the minor. The adult (parent/guardian) accompanying the minor child to the first visit is responsible for any balances not covered by the insurance company. Minors not accompanied by an adult will be rescheduled if the appointment is non-emergent. If the parent/guardian gives written permission to treat without a parent present and the charges have been preauthorized for payment prior to treatment, then the minor can be treated.

COPAYMENTS: Your insurance requires that we collect your designated copay at the time of service. Please be prepared to pay the copay at each visit.

SELF PAY: Self pay accounts may exist if a patient has no insurance coverage. For new patients, a payment of $145 is due at the time of the appointment before being seen by the healthcare provider. For established patients with no insurance coverage, a payment of $100 is expected on the day of your appointment before being seen by the healthcare provider. Additional charges apply for other services rendered the day of your appointment, such as blood work, x-rays, and EKG.

REFERRALS: If your plan requires a referral from your PCP, it is your responsibility to obtain this prior to your appointment and to have it with you at the time of your appointment. If you do not have the referral, you may be required to reschedule the appointment.

RETURNED CHECKS: Any returned check from the bank for non-payment shall result in the patient's account being charged a $35 returned check fee. We reserve the right to require future payments to be made by credit card, money order, or cash.

AGREEMENT TO PAY AND ACCEPTANCE OF PAYMENT POLICY: I, the undersigned, accept the fees charged are due at the time of service. Should it be necessary to forward my account for collection, I agree to pay all money due, attorneys' fees, and/or court costs. I waive my right of exemption under the Constitution of the State of Alabama and any other state. I give Lister Healthcare, its employees and agents express prior consent to contact me for the purpose of treatment, insurance, and/ or payment.

I have read and understand the Lister Healthcare Financial Policy. I agree to the terms and conditions.

SIGNATURE: ______________________________ **DATE:** ____________________

LISTER HEALTHCARE HEALTH HISTORY

PATIENT NAME: ______________________________ **DOB:**______________ **DATE:** ______________

REASON FOR VISIT:____

PREVIOUS PCP:_____________________

<u>CHRONIC CONDITIONS/SERIOUS ILLNESSES HISTORY:</u> Please circle any that apply.

AIDS/ HIV
Alcoholism
Anemia
Anxiety/ Depression
Arthritis
Asthma
Bleeding Disorders

Breast Lump
Bronchitis
Cancer
Cataracts
Chemical Dependency
COVID
Diabetes
Edema

Emphysema
Epilepsy
GERD
Glaucoma
Goiter
Gout
Heart Disease
Hepatitis

Hernia
High Cholesterol
High Blood Pressure
Kidney Disease
Liver Disease
Migraines
Miscarriage

Multiple Sclerosis
Pacemaker
Pneumonia
Prostate Problems
Psychiatric Care
Stroke

Suicide Attempt
Thyroid Problems
Tuberculosis
Ulcers
STD's

Other Conditions Not Listed: ____

<u>MEDICATION LIST</u>: List name, dose, & frequency.

____

____

____

____

____

____

____

<u>PHARMACY</u>: ____________________________________

<u>ALLERGIES</u>: _____________________________________

<u>OCCUPATION</u>: ___________________________________

<u>NUMBER OF PREGNANCIES</u>: _____________

SOCIAL HISTORY: Please indicate any of these that you use and the frequency of use.

TOBACCO: ______________________________

ALCOHOL: ______________________________

STREET DRUGS: ______________________________

SURGICAL HISTORY : Please list surgeries. ______________________________

____

SPECIALISTS: ______________________________

FAMILY HISTORY: Information concerning Immediate Family Members

RELATION	AGE	AGE AT DEATH	CAUSE OF DEATH
MOTHER			
FATHER			
SIBLING			
SIBLING			
SIBLING			
SIBLING			

Please check if any blood relatives have had any of the following and list relationship.

Arthritis/Gout ______________ Asthma/Hay Fever ______________

Cancer ______________ Dependency ______________

Diabetes ______________ Heart Disease/ Stroke ______________

High Blood Pressure ______________ Kidney Disease ______________

Other Conditions Not Listed: ______________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Mammogram (Females) Y/N DATE AND RESULT: ______________

PAP Smear (Females) Y/N DATE AND RESULT: ______________

Bone Density (Females) Y/N DATE AND RESULT: ______________

Colonoscopy Y/N DATE AND RESULT: ______________

Stress Test Y/N DATE AND RESULT: ______________

Flu Vaccine (this season) Y/N DATE AND RESULT: ______________

Pneumonia Vaccine Y/N DATE: ______________

PATIENT SIGNATURE: ______________________________ **DATE** ______________

THE PATIENT HEALTH QUESTIONAIRE

PATIENT NAME: ________________________________ **DATE:** ______________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than normal	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

COLUMN TOTALS _____ + _____ + _____

ADD TOTALS TOGETHER ___________

10. If you have checked off any of the problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?
___ Not difficult at all ___ Somewhat difficult ___ Very difficult ___ Extremely difficult