LIGHTHOUSE
FAMILY MEDICINE

Date_____

Dear_____

Thank you for scheduling your appointment with us on _____ . It is our pleasure to welcome you to Lighthouse Family Medicine.

Enclosed you will find a new patient information packet. Please complete the forms and bring them with you to your appointment. If you have any questions we will be glad to answer them when you arrive. We will review your health history with you at the time of your visit. We would also ask that you bring all of your current medication containers. This will allow our staff to accurately record your medication, with dosages and frequency, to your new medical record.

Please plan to arrive at least 15 minutes before your scheduled visit time. Upon registering, the receptionist will scan your insurance cards and driver's license or another form of photo I.D. Please have these cards available. We have also included a medical release form for you to send to your previous primary care physician and/or current consulting physician(s) to enable us to obtain any pertinent health information regarding your care.

It is important to us to meet all of your healthcare needs. We will always try our best to accommodate you for same day sick visits, knowing that many people would prefer to see their own provider when they are ill.

We appreciate you selecting us for your medical care, and are honored to be part of your health journey. Together we can work on the best solution to achieve your health goals.

Sincerely,

Beau Dowden, M.D.

Joshua Adams, M.D.

Linda Esch, FNP-BC

Alicia McNary, FNP-C

Charli Souza, FNP-BC

LIGHTHOUSE
FAMILY MEDICINE

PATIENT PORTAL

Our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely via the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- ask questions of doctors, nurses, and staff members
- request prescription refills and referrals
- set up appointments
- view your personal health record
- examine your current and past statements

… all from the comfort of your home, whenever it is convenient for you!

By using the Patient Portal, you no longer have to call the office, leave a message, and wait for a response to get the results of your lab work; those results will be available to you through the Portal. You can also send a message to the office through the Portal and expect a prompt reply.

To learn more or to sign up, contact our office today at 810.824.4222. Or, go to our URL, https://mycw11.eclinicalweb.com/portal266/jsp/login.jsp, and follow the simple directions to register. The patient portal is also located on our website, www.lighthousefamilymedicine.net. There is also a great app, Healow, which you can get for FREE at the App Store or Google Play! Begin today to take an active role in managing your healthcare!

TELEMEDICINE

What is TeleMedicine?
TeleMedicine is a one-on-one visit completed through a secure internet connection through the Patient Portal or Healow App. This visit takes place over the internet via computer, cell phone, or iPad. You are able to see one of our health care providers in real time to discuss your health concerns. In most cases the provider will be able to make recommendations, review test results, prescribe medications as deemed necessary, and schedule follow-up care.

Why TeleMedicine?
TeleMedicine visits are a convenient way to provide medical care. Whether you are at home, work, or traveling all you need is a private space and internet access. Prescriptions can be sent electronically if needed.

How Do I Pay for TeleMedicine?
TeleMedicine is a cash only service. The cost is $50.00 per visit and no insurance will be billed. Please call our office to pay over the phone or pay online via your patient portal.

Are You Ready For TeleMedicine?
- Call our office to schedule your TeleVisit appointment 810.824.4222
- You will need to ensure you are web-enabled by providing a working email address to our office.
- Once your patient portal is active you will have a user name and password.
- Download the Healow App or Log in via Patient Portal with your username and password 15 minutes prior to appointment.

LIGHTHOUSE
FAMILY MEDICINE

ADULT HEALTH INFORMATION FORM: DATE: _____

The more information we know about you and your family, the better medical care we can provide you. None of this information will be released to any person except with your written consent.

LAST NAME _____ FIRST _____ MI _____

BIRTHDATE _____ SEX ◯ M ◯ F ◯ TRANSGENDER MARITAL STATUS ◯ M ◯ S ◯ D ◯ W

ADDRESS _____ CITY _____ STATE _____ ZIP _____

S.S.# _____ PHONE NUMBER _____

RACE _____ ETHNICITY _____ LANGUAGE _____

EMPLOYER _____ OCCUPATION _____

WORK PHONE# _____ PRIMARY INSURANCE _____

SUBSCRIBER NAME/DOB _____

SECONDARY INSURANCE _____ SUBSCRIBER NAME/DOB _____

NOTIFY IN CASE OF EMERGENCY _____

Name *Relationship to Patient* *Phone #*

MAIN REASON FOR VISIT TO THE DOCTOR _____

Spouse's Name _____

Children/Ages _____

E-MAIL ADDRESS _____

We can send your lab/test results electronically.
E-mail will not be used for solicitation or shared with 3rd parties.

LIGHTHOUSE
FAMILY MEDICINE

ASSIGNMENTS OF BENEFITS

Assignment of Benefits is giving Lighthouse Family Medicine permission to file claims to your insurance on your behalf. If this document is not signed you will need to file your own medical claims with your insurance company.

I hereby authorize payment to **Lighthouse Family Medicine** benefits specified and otherwise payable to me for any services rendered by the clinic subsequent to this date and for such other charges as may be made by said clinic. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related medical claims. I request that payment of Authorized Benefits be made on or in my behalf to **Lighthouse Family Medicine**.

I, the undersigned, certify that I have read the foregoing, and am the patient, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

PATIENT NAME _____ DATE _____

SIGNATURE _____

LIGHTHOUSE
FAMILY MEDICINE

CONSENT FOR TREATMENT

The PATIENT acknowledges being informed in writing that an HIV test may be performed on PATIENT without written consent in the event that an employee of Lighthouse Family Medicine is exposed to PATIENT'S blood or body fluids.

Lighthouse Family Medicine is authorized to release medical or other information related to services PATIENT has received, including any alcohol, drug or mental health records, HIV infection, AIDS and AIDS Related Complex (ARC) records to Medicare, its intermediaries, Medicaid or any commercial insurance from which PATIENT may be entitled to health insurance benefits as may be necessary for Lighthouse Family Medicine to receive payment for services. The PATIENT hereby assigns benefits and payment requests to Medicare, Medicaid or other third party carriers. The undersigned acknowledges responsibility and agrees to pay in full all remaining balances of unpaid charges due to deductibles, co-insurance or absence of insurance benefits. Lighthouse Family Medicine is authorized to release any information required in order for an outside credit agency to collect this amount.

I hereby authorize Lighthouse Family Medicine and it's employees to furnish all insurance companies any information which they may request including photocopies from my medical records as necessary for completion of my claim, or as may be required by law for this treatment.

I further authorize Lighthouse Family Medicine and it's employees to furnish information from my medical records pertaining to this treatment as requested by other physicians or medical care facilities for my continued care and treatment.

Lighthouse Family Medicine is released from all responsibility for loss or damage of personal property not retained in the PATIENT'S possession. I certify that all the information I have given to Lighthouse Family Medicine is correct.

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by **Lighthouse Family Medicine** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Lighthouse Family Medicine.** I understand that diagnosis or treatment of me by **Lighthouse Family Medicine** may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Patient Signature (Parent/Guardian if Patient is a Minor)	Relationship (if not Patient)	Date

LIGHTHOUSE
FAMILY MEDICINE

PATIENT FINANCIAL POLICY

The following is a statement of our **Patient Financial Policy.** Please take a moment to review and sign prior to any treatment.

Our physicians accept assignment of insurance benefits from many of the major insurance companies. Please check with the physician's office prior to treatment on which companies they participate with.

- You will be asked to present your insurance card every visit.
- For patients who are covered by a medical insurance that the physician "participates with", payment of any applicable **co-pays and/or deductibles are required and appreciated at the time of service.**
- For patients who are not covered by medical insurance, or have a medical insurance that the physician does not participate with, we reserve the right to require full payment at the time of service.
- You may be asked to sign an Advanced Beneficiary Notice. This form will hold you financially responsible for Non Covered services. It is a patient's responsibility to check which services are covered and non covered.
- Patient Balances: Any balance on a patient's account must be paid in full prior to being seen. For balances over $100.00, a payment arrangement will be set up prior to the patient being seen by our office. Patient balances that are over 90 days old will be sent to an outside collection agency and a service fee of up to 20% may be assessed and our collection policy will be implemented. If sent to an outside collection agency a patient will be discharged due to non-payment.
- Missed Appointments: We reserve the right to charge a fee of **$40.00 for each missed appointment.** Maintaining scheduled appointments allows us to continue to provide the best possible medical care. Three no shows for an appointment may result in discharge from our practice.
- Same day cancellation: will be subject to a $25.00 fee.
- Returned Checks: A service fee of $50.00 will be charged for all checks that are returned for insufficient funds. Two returned checks result in cash/credit only.
- As a convenience, we accept cash, checks and most major credit and/or debit cards including Care Credit. Payments are also accepted through our patient portal.
- Billing representatives are available to assist you in billing inquiries, and arrange for payments in advance in the event of financial hardship. A mutually agreeable, realistic plan for payment will always be considered.
- An adult patient is financially responsible for services rendered, regardless of who is listed as the insurance policy holder.
- Minor Patients: All minors (anyone under the age of 18), must be accompanied by a parent and/or legal guardian at every visit.
- Financial responsibility for services rendered to minor patients is the sole responsibility of each parent and/or legal guardian, unless a Court Order is presented stating otherwise. Bills will be sent to the custodial parent or the address where the child resides.
- It is the patient's responsibility to inform the physician's staff of a**ny changes in their health insurance coverage prior to treatment.**

- Please remember, your medical insurance policy is a contract between you and your insurance company. Lighthouse Family Medicine can assist in some billing inquiries but ultimately it is your responsibility to address insurance issues.
- Any and all correspondence from your insurance company should be retained and reviewed for payment information of covered services, including “Explanation of Benefits” (EOB).
- Note: after 60 days, any unpaid insurance claims will be transferred to the patient’s financial responsibility for payment and/or follow-up with their insurance carrier.
- For those plans that require “prior authorizations”, and/or “written referrals” for coverage, the patient is responsible to obtain and present this information prior to treatment. Please be advised that we reserve the right to refuse treatment for non-emergent conditions, unless prior authorization has been obtained.
- Non-fulfillment of financial obligations may result in discharge from Lighthouse Family Medicine.
- We reserve the right to uphold and enforce this financial policy in its entirety. This financial policy cannot be altered in any way and must be signed and agreed to as is prior to a patient rendering services at Lighthouse Family Medicine.

X (Patient Name) _____

X _____ Date: _____

(Signature of Patient or Responsible Party)

_____

(Please Print Name of Person Signing Above)

LIGHTHOUSE
FAMILY MEDICINE

Consent for Disclosure of Protected Health Information for Purposes of Treatment, Payment and Healthcare Operations.

I consent to the use or disclosure of my protected health information by **Lighthouse Family Medicine** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Lighthouse Family Medicine**. I understand that diagnosis or treatment of me by **Lighthouse Family Medicine** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice**. Lighthouse Family Medicine** is not required to agree to the restrictions that I may request. However, if **Lighthouse Family Medicine** agrees to a restriction that I request, the restriction is binding on **Lighthouse Family Medicine.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Lighthouse Family Medicine** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review **Lighthouse Family Medicine's** Notice of Privacy Practices prior to signing this document. The **Lighthouse Family Medicine's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations **of Lighthouse Family Medicine**. The Notice of Privacy Practices **for Lighthouse Family Medicine** is kept in the reception area of the office. This Notice of Privacy Practices also describes my rights and **Lighthouse Family Medicine's** duties with respect to my protected health information.

Lighthouse Family Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative.

NOTICE OF PRIVACY PRACTICES POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Medical Record/Health Information

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care of treatment.

Your Health Information Rights

Your health record is the physical property of this practice, however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your requests for any of these actions:

1. Request Restrictions: You have a right to request restrictions on the use of your information.
2. Obtain a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice.
3. Inspect and Copy: You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor postage and supplies used.
4. Amend: You have the right to request that we amend your health information.
5. Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes those disclosures of your information other than treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve month period.
6. Request Communications of your Health Information: You have the right to request that you receive communications regarding your information in a certain manner of at a certain location.
7. Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

Our Responsibilities

Our practice is required to:

1. Confidentiality: Maintain the privacy of your health information.
2. Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.
5. Provide alternative means or alternative locations: We will accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations.
6. We reserve the right to charge our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office.
7. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information

1. If you have a question or would like to additional information, you may contact our privacy officer.
2. If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice, but you may also file a complaint with the secretary of Health and Human Services in the U.S Office of Civil Rights. The privacy officer will supply information about this procedure.

Examples of Disclosures of Information

1. Treatment:
    a. We will use your health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations. In the process of providing care to me, my health information may be electronically transmitted, verbally shared, and communicated in writing. In the process of providing care to me, my health information may be electronically transmitted, verbally shared, and communicated in writing.
    b. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.
2. Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identities you, your diagnoses, treatments and supplies used.
3. Healthcare Operations: The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.
4. Business Associates: There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associates that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.
5. Notification: We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.
6. Communications with family: We will use good judgment in disclosing to a family member or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.
7. Funeral Directors: We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.
8. Organ Donations: If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donations and transplantation purposes.
9. Marketing: We may contract you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be or interest to you.
10. Food and Drug Administrations: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.
11. Workers Compensations: In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.
12. Public Health: Under law, we may disclose your health information to the health department in order to prevent or control disease, injury or disability.
13. Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
14. Health investigation: Federal and state laws make provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers, or the public.
15. Other disclosures: All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

Acknowledgement of Receipt of Privacy Practices

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Name of Patient or Personal Representative

LIGHTHOUSE
FAMILY MEDICINE

ALLERGIES OR ADVERSE REACTIONS TO MEDICATION OR FOODS - ALLERGY REACTION

PHARMACY NAME AND LOCATION _____

PREFERRED LAB COMPANY _____

CURRENT MEDICATIONS: (Include prescriptions and over the counter meds.) ***Please bring ALL prescription bottles to each office visit.***

MEDICATION	DOSE	DIRECTIONS

SURGERIES:

DATE OR YEAR	

HOSPITALIZATIONS:

DATE OR YEAR	REASON

SERIOUS ILLNESSES: _____

Form 0011

LIGHTHOUSE
FAMILY MEDICINE

PATIENT'S MEDICAL HISTORY (AGE FIRST STARTED OR YEAR)

○ Alcoholism	_____	○ Epilepsy	_____	○ Pneumonia	_____
○ Anemia	_____	○ Glaucoma	_____	○ Polio	_____
○ Anorexia	_____	○ Gout	_____	○ Prostate Problem	_____
○ Arthritis	_____	○ Heart Disease	_____	○ Psychiatric Care	_____
○ Asthma	_____	○ Hepatitis	_____	○ Rheumatic Fever	_____
○ Bleeding Disorder	_____	○ Hernia	_____	○ Scarlet Fever	_____
○ Breast Lump	_____	○ High Blood Pressure	_____	○ Stroke	_____
○ Bronchitis, Chronic	_____	○ High Cholesterol	_____	○ Suicide Attempt	_____
○ Bulimia	_____	○ HIV Positive / AIDS	_____	○ Thyroid Problem	_____
○ Cancer	_____	○ Kidney Disease	_____	○ Tuberculosis	_____
○ Cataracts	_____	○ Liver Disease	_____	○ Thyphoid Fever	_____
○ Chemical Dependency	_____	○ Measles	_____	○ Ulcers	_____
○ Chicken Pox	_____	○ Migraine Headache	_____	○ Vaginal Infection	_____
○ Depression	_____	○ Mononucleosis	_____	○ Other	_____
○ Diabetes	_____	○ Mumps	_____		_____
○ Emphysema	_____	○ Pacemaker	_____		_____

FOR WOMEN ONLY

Are you pregnant? ○ Yes ○ No

Age when periods started ○ 10-12 ○ 13-15 ○ 16 and older

Last pap smear ○ < 1yr ○ 1-2yrs ○ 3+yrs

Periods are: ○ Regular ○ Irregular

Flow: ○ Heavy ○ Light ○ Average

Pain: ○ Painful ○ Mild ○ Average

Last Menstrual Period: _____

Number of Pregnancies ○ NA ○ Yes _____

Premature Births ○ NA ○ Yes _____

Miscarriages ○ NA ○ Yes _____

Twins ○ NA ○ Yes _____

Abortions ○ NA ○ Yes _____

Living Children ○ NA ○ Yes _____

FOR PATIENTS OVER AGE 65: If you need help with any of the following please fill in oval completely.

Dressing	○ No ○ Yes	Shopping	○ No ○ Yes
Bathing	○ No ○ Yes	Paying Bills	○ No ○ Yes
Walking	○ No ○ Yes	Driving	○ No ○ Yes
Getting out of chair/bed	○ No ○ Yes	Feeding	○ No ○ Yes

LIGHTHOUSE
FAMILY MEDICINE

Please fill in oval completely like this ● Please do not use X or ✔

FAMILY HISTORY

	Alive	Deceased	Cancer: Breast	Cancer: Ovarian	Cancer: Colon	Cancer: Uterine	Cancer: Blood	Cancer: Lung	Cancer: Prostate	Heart Attack	High BP	Stroke	Blood Clots: in Legs	Blood Clots: in Lungs	Diabetes	Thyroid	Mental Illness/ Depression	Osteoporosis	Alcohol or Drug Problems
Father	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Mother	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Paternal Grand Father	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Paternal Grand Mother	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Maternal Grand Father	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Maternal Grand Mother	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Children:																			
1.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
2.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
3.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
4.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
5.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Siblings:																			
1.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
2.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
3.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
4.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
5.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

SOCIAL HISTORY

Smoking - Packs/Day ○ None ○ Former ○ ½ ○ 1 ○ 2 ○ More than 2

Sexual History - Sex in the past 12 months (vag, oral, anal) ○ Yes ○ No Ever had Sexually Transmitted Disease ○ Yes ○ No

Drug Use ○ None ○ Occasional ○ Frequent

Alcohol ○ No ○ Yes - Monthly or less? ○ 2-4x month ○ 2-3x ○ 4+ or more /week

Caffine - Cups/Day ○ None ○ 1-2 ○ 3-6 ○ More than 6

Work ○ Full ○ Part Time ○ Not Currently Working ○ Disabled

Domestic Abuse ○ Never ○ In the Past ○ Yes

Exercise Days/Week ○ None ○ 1-2 ○ 3-6 ○ More than 6

Marital Status ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Sexual Abuse ○ Never ○ In the Past ○ Yes

Sexually Active ○ No ○ Monogamous Relationship ○ More than one Partner
○ Uses condom ○ Use birth control method

Travel outside US ○ None in the last 6 months ○ Travels to South America ○ Travels to Europe
○ Asia ○ Africa

Verbal Abuse ○ None ○ Occasional ○ Frequent ○ Seeking Counseling ○ Has safe plan

Any Military ○ None ○ Former ○ Yes

Religious Preference ○ Yes ○ No Type: _____

LIGHTHOUSE
FAMILY MEDICINE

Please fill in oval completely like this ● for any symptoms which have been a serious or frequent problem for you.

CONSTITUTIONAL
- ○ Fatigue
- ○ Weight change
- ○ Fever
- ○ Weakness
- ○ None

EYES
Last Eye Exam
- ○ Within 2 years
- ○ More than 2 years

- ○ Blurring vision
- ○ Glaucoma
- ○ Cataracts
- ○ Glasses/Contacts
- ○ None

ENT
Last Dental Exam
- ○ Within 2 years
- ○ More than 2 years

- ○ Difficulty hearing
- ○ Ringing in ears
- ○ Nosebleeds
- ○ Sore throat or mouth
- ○ Hoarseness
- ○ Frequent colds
- ○ Postnasal drip
- ○ Dry mouth
- ○ None

GASTROINTESTINAL
- ○ Abdominal pain
- ○ Change in appetite
- ○ Nausea or vomiting
- ○ Rectal bleeding/Black Stool
- ○ Diarrhea or Constipation
- ○ Hemorrhoids
- ○ Excess gas
- ○ Heartburn
- ○ Difficulty swallowing
- ○ None

GENITOURINARY
- ○ Menstrual problems/Irregularity
- ○ Sexually transmitted disease
- ○ Urinating Frequently
- ○ Burning pain with urination
- ○ Dribbling or trouble starting
- ○ Getting up many times to urinate at night
- ○ Incontinence
- ○ Sexual problems
- ○ Penile/Vaginal discharge
- ○ None

NEUROLOGICAL
- ○ Headache
- ○ Seizure
- ○ Weakness
- ○ Fainting/Blackouts
- ○ Paralysis
- ○ Tingling
- ○ Memory loss
- ○ Tremors
- ○ Loss of coordination
- ○ Dizziness
- ○ None

PSYCHIATRIC
- ○ Mood changes
- ○ Nervousness/Irritability
- ○ Sleep disturbance
- ○ Depression
- ○ Stress
- ○ Difficulty concentrating
- ○ Thoughts of suicide
- ○ None

ALLERGIC
- ○ Runny nose
- ○ Itchy eyes
- ○ Seasonal Allergies
- ○ None

CARDIOVASCULAR
- ○ Chest pain or pressure
- ○ Palpitations
- ○ Varicose Veins
- ○ Swelling in Feet
- ○ None

RESPIRATORY
- ○ Shortness of breath
- ○ Wheezing
- ○ Cough
- ○ None

MUSCULOSKELETAL
- ○ Leg cramps/pain walking
- ○ Back/Neck Pain
- ○ Joint swelling or pain
- ○ Muscle tenderness
- ○ None

SKIN AND BREAST
- ○ Breast lumps or pain
- ○ Nipple discharge
- ○ Rashes
- ○ Change in skin color
- ○ Itching
- ○ Changing/new moles
- ○ Hair/nail changes
- ○ None

ENDOCRINE
- ○ Excessive thirst/hunger
- ○ Heat or cold intolerance
- ○ Thyroid problems/Goiter
- ○ Excessive sweating
- ○ None

HEMATOLOGIC
- ○ Tender/enlarged lymph nodes
- ○ Anemia
- ○ Bruising/Easy bleeding
- ○ Blood transfusion
- ○ None

LIGHTHOUSE
FAMILY MEDICINE

I give Lighthouse Family Medicine authorization to release information regarding my health to the following people: (i.e. spouse, siblings, parents, etc.) Please note that anyone not listed on this form, including immediate family members and/or relatives, **will not** have access to any information in your medical file, nor be able to pick up written prescriptions, samples, or copies of results.

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Patient Signature _____ Date _____

If our office cannot reach you personally, may we leave protected health information (i.e. test results, appointment dates, returned messages, etc.) by the following methods:

With a family member: Yes_____ No_____

Home answering machine: Yes_____ No_____

Cellular Phone Voicemail: Yes_____ No_____ Cell Phone# ( )_____-_____

By mail to home address: Yes_____ No_____

Patient Signature _____ Date _____

LIGHTHOUSE
FAMILY MEDICINE

BEHAVIOR POLICY

Unfortunately, due to the behavior of a very small number of our patients we find it necessary to implement a policy to outline unacceptable behavior and the consequences of such behavior. Here at Lighthouse Family Medicine we strive to treat each patient with compassion, competence and respect. Each person on our staff is dedicated to your health and wellbeing. We attempt to meet everyone's multiple and varying needs and to do so efficiently and respectfully. We understand that on occasion people may get frustrated but we still expect to be treated courteously and respectfully. The policy is outlined below.

- Offense 1: A verbal notification that the behavior exhibited is unacceptable and/or disrespectful.
- Offense 2: A written letter given to the patient or mailed to their house informing them this is the second offense.
- Offense 3: The patient is discharged from the practice. As in any other discharge policy, we will continue to provide prescription refills except controlled substances for 30 days while an alternative provider is sought.

We cannot include all behavior that would fall under the umbrella of unacceptable or disrespectful, however, some examples include yelling or raising one's voice while speaking to staff or provider either in person or on the phone, using profanity, and disrespectful language.

The staff and providers at Lighthouse Family Medicine truly hope we never have to implement this policy with any person seeking care here and are disheartened this policy is necessary. We hope to provide a caring and pleasant environment for everyone.

LIGHTHOUSE
FAMILY MEDICINE

Authorization to Disclose Health Information

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE: _____

1. I authorize the use or disclosure of the above named individual's health information as described below
2. The following individual or organization is authorized to make the disclosure

   _____

3. The type and amount of information to be used or disclosed is as follows:

☐ problem list
☐ most recent provider encounter
☐ procedure record
☐ laboratory results
☐ x-ray and imaging reports
☐ entire record
☐ medications list
☐ immunization record
☐ most recent history and physical
Dates: from _____ to _____
Dates: from _____ to _____
☐ Other: _____

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization
   LIGHTHOUSE FAMILY MEDICINE

   Purpose of release:
   ☐ Medical Care ☐ Legal representation
   ☐ Other: _____
6. I understand that I have the right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked this authorization will expire in six months from the date of authorization.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment by my healthcare providers. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal or state privacy rules. If I have questions regarding the disclosure of my health information by this practice, I can contact the privacy officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Signature of Witness

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