Registration Information

Name:_____ Today's Date_____

DOB:_____ Age:_____ Sex:_____ SSN:_____

Telephone # _____

Email:_____

Adress:_____

_____

City:_____State:_____Zip:_____

Occupation:_____Employer:_____

Emergency Contact: _____Contact #:_____

Relationship to patient:_____

Primary care provider:_____

Marital Status:_____

Insurance Provider_____

*Provide insurance card to the front desk so we can make a copy.

Reason for today's visit: please check all that apply.

[ ]Discuss hormone replacement therapy.

[ ]Discuss IV therapy / receive IV Therapy

[ ]Discuss procedural therapy.

[ ]PRP

[ ]Other: _____

How did you hear about us?_____

What are your goals for today's visit?_____

LivingHealthy MD

Name _____

DOB _____

----------Patient Intake Form----------

Past Medical History: Please check all that apply.

[ ] High Blood Pressure	[ ] Thyroid Disease	[ ] GERD (acid reflux)	[ ] Irregular Heartbeat
[ ] Diabetes	[ ] History of cancer:	[ ] Anemia	[ ] Seizure Disorder
[ ] High Cholesterol	Type:_____	[ ] Hepatitis	[ ] Anxiety
[ ] Heart Disease	[ ] Gall Bladder Disease	[ ] HIV	[ ] Bruise easily
[ ] History of heart attack	[ ] Liver Disease	[ ] Osteoporosis	[ ] Depression
[ ] Asthma	[ ] Kidney Disease	[ ] Arthritis	[ ] Migraines
[ ] COPD	[ ] History of Stroke	[ ] Mental Illness	[ ] Insomnia
[ ] Intestinal/Colon Disease	[ ] Swelling of Limbs	[ ] Overweight	[ ] Sleep Apnea
[ ] History of Drug Addiction	[ ] Post Covid Syndrome	[ ] Low Blood Pressure	[ ] Low blood sugar

Additional history not listed above : _____

_____

Past Surgical History:_____

_____

Any recent surgeries? [ ] yes [ ] no

Medications: please list all prescription and over the counter medications.

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Allergies: _____ _____ _____ _____

_____ _____ _____ _____ _____

Latex Allergy? [ ] yes [ ] no

Trouble with anesthesia/sedation? [ ] yes [ ] no If yes, what reaction? _____

Trouble with local anesthesia? [ ] yes [ ] no If yes, what reaction? _____

Are you currently taking :

Blood Thinners [ ] yes [ ] no

Steroids [ ] yes [ ] no

Antibiotics [ ] yes [ ] no

Continue next page

Social History: Please check all that currently apply.

Tobacco Use:

[ ] Never

[ ] Quit / When? _____

[ ] Cigarettes / Pack per day? _____

[ ] Pipe

[ ] Cigars

[ ] Chewing Tobacco / Dip

Alcohol use:

[ ] None

[ ] Socially

[ ] Daily: drinks per day_____

Have you ever been treated for alcoholism?

[ ] yes [ ] no If yes, When? _____

Drug Use:

[ ] None

[ ] Marijuana

[ ] Amphetamines

[ ] Cocaine

[ ] Other:_____

Exercise

[ ] None

[ ] 1-2 times per week

[ ] 3-4 times per week

[ ] 5-7 times per week

What type of exercise: _____

Have you ever been treated for drug use? [ ] yes [ ] no If yes, when? _____

Any religious beliefs that would affect your medical care? [ ] yes [ ] no

Education: Please check highest level.

[ ] Grade school [ ] High school [ ] College [ ] Graduate school

Family History

Family Member	Medical History
Father	
Mother	
Brother(s)	
Sister(s)	

Females:

Are you pregnant? [ ] yes [ ] no Are you breastfeeding? [ ] yes [ ] no

Last menstrual period? _____ Birth control method? _____

Males:

Do you experience impotency? [ ] yes [ ] no Erectile problems? [ ] yes [ ] no

Have you had COVID 19 and still have residual symptoms? [ ] yes [ ] no

Patient sticker

Hormone Symptom Questionnaire

Please check if you have any of the following symptoms:

[ ] Hot flashes

[ ] Sweating (night sweats or increased episodes of sweating

[ ] Sleep problems

[ ] Depressive mood (feeling down, sad, on the verge of tears, lack of drive)

[ ] Irritability (mood swings, feeling aggressive, anger easily)

[ ] Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)

[ ] Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina, or motivation)

[ ] Sexual problems (change in sexual desire, sexual activity, orgasm, and/or satisfaction)

[ ] Bladder problems (difficulty urinating, increased need to urinate, incontinence)

[ ] Vaginal symptoms (dryness or burning sensations, difficulty with intercourse)

[ ] Erectile changes (weaker erections, loss of morning erections)

[ ] Joint and muscular symptoms

[ ] Difficulty with memory

[ ] Problems with thinking, concentrating, or reasoning.

[ ] Difficulty with learning new things

[ ] Trouble thinking of the right word to describe persons, places or things while speaking.

[ ] Increase in frequency or intensity of headaches or migraines.

[ ] Hair loss, thinning or change in texture of hair.

[ ] Feel cold all the time or have cold hands or feet.

[ ] Weight gain or difficulty losing weight despite diet and exercise.

[ ] Dry or wrinkled skin

Are you currently taking hormone replacement therapy? [ ] yes [ ] no What type?_____

Females- Have you ever had any of the following (check all that apply): [ ] Breast cancer [ ] uterine cancer [ ] Ovarian Cancer [ ] PCOS [ ] Acne [ ] Excess facial/body hair [ ] Infertility [ ] Endometriosis [ ] Epilepsy or seizures [ ] Fibrocystic breast/pain [ ] Uterine fibroids [ ] Irregular/heavy menstrual cycles [ ] Hysterectomy-complete [ ] Hysterectomy -partial.

Birth control method:_____ **Any possibility of being pregnant? [ ] yes [ ] no**

Males – Have you had any of the following (check all that apply): [ ] Cancer [ ] Elevated PSA [ ] taking medication for prostate of male pattern balding [ ] Anemia [ ] Erectile dysfunction [ ] Testicular or prostate cancer [ ] Prostate enlargement [ ] kidney disease [ ] History of prostate surgery [ ] Sleep apnea/severe snoring [ ] Taking medication for cholesterol.

Dr. John Roberts

3626 Memorial Pkwy SW, Huntsville, AL 35801

2117 Veterans Dr. SE, Decatur, AL 35601

122 Helton Court, Florence, AL 35630

Crestwood Medical Center, Madison Surgery Center, Decatur Surgery Center, Shoals Surgery Center

Phone: 256-715-7483

Fax: 256-715-7414

EFFECTIVE IMMEDIATELY

NO SHOW AND CANCELLATION POLICY

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or canceling an appointment late means we are unable to fill this appointment time with another patient who needs our care. We are now implementing a NO SHOW fee for missed or late arrival appointments. This will include all locations and facilities.

_____ Initials

Timely cancellations: If you need to cancel or reschedule your appointment, you must give at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment, and you will be charged $75.00.

_____Initials

Arrivals: We ask that you arrive 10-15 before your scheduled appointment time. If you are more than 30 minutes late for your scheduled appointment time, we will give your appointment to another patient. This will be considered a missed appointment, and you will be charged $75.00.

_____ Initials

Compliance: Patients are given several opportunities to reschedule and cancel their appointment via text message, phone call, and email. If you are not receiving your appointment reminders, please notify our staff immediately.

Signature_____

Printed Name _____Date_____

John R. Roberts, MD

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Authorization to Disclose Health Information

Patient Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Date of Service _____

I authorize the use of disclosure of the above-named individual's health information as described below:

1. _____ is authorized to make disclosure.
2. The type and amount of information to be used or disclosed as follows: (including date)

_____History and Physical _____Pathology Report

_____Progress Notes _____EKG Report

_____Laboratory Results _____Operative Note

_____Emergency Department Records _____Imaging Results (Reports)

_____Other _____

I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavior or mental health services, and treatment for drug and alcohol abuse.

This information may be disclosed to and used by the following individual organization.

Living Healthy MD/ John R. Roberts, MD

3626 Memorial Pkwy SW, Huntsville, AL 35801

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122 Helton Court, Florence, AL 35630

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the office staff. I understand that the revocation will not apply to information that has already been released in my response to this authorization.
I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient, and information may not be protected by federal privacy regulations. I understand as a recipient, I am responsible for the security of these medical record copies and health information contained therein in paper and electronic format.
I understand that I need not sign this form to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits.

Signature _____ Date _____ Time _____

Relationship to patient _____

Witness Signature _____ Date _____ Time _____

LivingHealthy MD

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you.

The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment, and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.

The patient understands that:

- Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Practice reserves the right to change the Notice of Privacy Policies as followed by law.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those. Practice
- The patient may revoke this Consent in writing at any time, and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

May we phone, leave a message, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave a voice message at your home or on your cell phone? **YES** **NO**

May we discuss your medical condition with another doctor or hospital? **YES** **NO**

May we discuss your medical condition with a member of your family? **YES** **NO**

If yes, please name members allowed:_____

_____

Signature_____ Date_____

Print Name _____

Witness_____ Date_____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

This Patient Financial Responsibility Agreement is entered into by and between_____("Patient") and Living Healthy MD ("Provider"). This Agreement outlines the financial responsibilities of the Patient regarding medical services provided by the Provider. It aims to provide clarity on payment obligations, insurance coverage, and the potential costs associated with medical care to ensure that Patients understand their financial commitments.

Purpose of Agreement

This Agreement establishes the Patient's acknowledgment and acceptance of their financial responsibility for all medical services and treatment received from the Provider. The Patient understands that this Agreement represents a binding obligation to ensure payment for services rendered.

This Agreement covers all healthcare services provided to the Patient by the Provider, including but not limited to consultations, examinations, diagnostic procedures, laboratory tests, treatments, and follow-up care. The Patient acknowledges that certain services may not be covered by insurance and may require separate financial arrangements. The Patient hereby agrees to pay for all services rendered by the Provider. This obligation includes, but is not limited to, the following:

- Payment for any services not covered by the Patient's insurance.
- Payment for all deductibles, co-payments, and coinsurance amounts as determined by the Patient's insurance plan.
- Payment of any balance remaining after insurance processing; and
- Payment in full for all services if the Patient does not have insurance coverage.

  - The Patient is responsible for providing accurate and complete insurance information prior to service delivery.
  - The Patient authorizes the Provider to verify insurance coverage and benefits.
  - The Patient acknowledges that insurance verification is not a guarantee of payment by the insurance company, and the Patient remains financially responsible for services rendered regardless of insurance coverage determinations.
  - The Patient acknowledges that if balances are not paid in a timely manner the Provider reserves the right to appropriately dismiss the patient from our care and forward unpaid balance to a collection agency.

The Patient acknowledges that pre-existing conditions, exclusions, or benefit limitations within their insurance policy may affect coverage for services provided. The Patient agrees to be financially responsible for any services that are denied or not covered due to such limitations. It is the Patient's responsibility to understand the terms and conditions of their insurance policy. Co-payments, as determined by the Patient's insurance plan, are due at the time services are rendered. Annual deductibles and any coinsurance percentages, as specified by the Patient's insurance plan, are the Patient's responsibility. The Patient acknowledges that these amounts represent a contractual obligation between the Patient and their insurance carrier.

By signing this Agreement, the Patient acknowledges receipt, review, and understanding of the terms contained herein. The Patient agrees to comply with all financial policies and procedures established by the Provider.

Printed Name_____Signature_____

Date _____

LivingHealthy MD

Pain Treatment with Opioid Medications: Patient Agreement

I, _____, understand and voluntarily agree that (initial each statement after reviewing):

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____I will participate in all other types of treatment that I am asked to participate in.

_____I will keep the medicine safe, secure, and out of reach of children. If the medication is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I will not call between appointments, at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____I will not sell this medication or share it with others. I understand that if I do, my treatment will stop.

_____I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____I will tell the doctor all other medicines that I take and let him/her know right away if I have a prescription for a new medication.

_____I will use only one pharmacy to get all my medications.

Pharmacy name/phone# _____

_____I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, Xanax, valium) or stimulants (Ritalin, amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information to reach me, and that any missed tests will be considered positive for drugs.

_____I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or cannot pay for treatment anymore.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at Living Healthy MD are making a commitment to work with you in your efforts to get better. To help you with this work, we agree that:

- We will help you schedule regular appointments for medicine refills. If we must cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.
- We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.
- We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.
- We will work with any other doctors or providers you see so that they can treat you safely and effectively.
- We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.
- If you become addicted to these medications, we will help you get treatment and get off the medications that are causing you problems safely.

_____ _____

Patient Signature Print Name

_____

Date

_____ _____

Provider Signature Print Name

_____

Date

LivingHealthy MD

Tobacco Control (Standard)

Tobacco Use:

- [ ] Current smoker [ ] Former smoker [ ] Nonsmoker [ ] Unknown if ever smoked.
- [ ] Everyday [ ] Occasional [ ] current status unknown
- [ ] Light tobacco smoker [ ] Heavy tobacco smoker [ ] Uses tobacco in other forms.

Additional Findings: Tobacco user

[ ] Rolls own cigarettes.

[ ] e-cigarette / Vape.

[ ] Trivial 0-1 cigarette a day [ ] Light 1-9 cigarettes a day [ ] Moderate 10-19 cigarettes a day

[ ] Heavy 20-39 cigarettes a day [ ] Very Heavy 40+ cigarettes a day [ ] Chain Smoker

[ ] Cigar Smoker

[ ] Pipe Smoker

[ ] Snuff user

[ ] Chews fine cut tobacco.

[ ] Chews loose leaf tobacco.

[ ] Chews plug tobacco.

[ ] Chews tobacco

[ ] Chews twist tobacco

[ ] Uses moist powder tobacco.

Additional Findings: Tobacco non-user

[ ] Current Nonsmoker

[ ] Current nonsmoker, history unknown

[ ] Aggressive nonsmoker

[ ] Intolerant nonsmoker

[ ] Tolerant nonsmoker

[ ] Nonsmoker for medical reasons

[ ] Nonsmoker for personal reasons

[ ] Nonsmoker for religious reasons

[ ] e-cigarette/vape smoker.

[ ] e-cigarette/vape smoker amount unknown.

- [ ] Former smoker, trivial 0-1 a day [ ] Former light smoker 1-9 a day [ ] Former moderate smoker 10-19 a day
  [ ] Former heavy smoker 20-30 a day [ ] Former very heavy smoker 40+ a day

[ ] Former cigar smoker

[ ] Former pipe smoker

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Name:_____

Date:_____

Please circle all that apply.

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

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ALCOHOL MISUSE / ABUSE (AUDIT C)

Did you have a drink containing alcohol in the past year?

[ ] Yes [ ] No

If 'Yes' : How often did you have a drink containing alcohol in the past year

[ ] Never (0 point)

[ ] Monthly or less (1 point)

[ ] 2-4 times a month (2 points)

[ ] 2-3 times a week (3 points)

[ ] Daily or almost daily (4 points)

[ ] Declined to specify (0 points)

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

[ ] 1-2 drinks (0 points)

[ ] 3-4 drinks (1 point)

[ ] 5-6 drinks (2 points)

[ ] 7-9 drinks (3 points)

[ ] 10 or more drinks (4 points)

[ ] Declined to specify (0 point)

If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?

[ ] Never (0 point)

[ ] Less than monthly (1 point)

[ ] 2-4 times a month (2 points)

[ ] 2-3 times per week (3 points)

[ ] 4 or more times per week (4 points)

[ ] Declined to specify (0 point)

Total Points _____

Interpretation

[ ] Positive

[ ] Negative

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use)

- **In men, a score of 4 or more is considered positive.**
- **In Women, a score of 3 or more is considered positive.**