Luz Family Medical and Wellness

Medical Records Request Form

This form is for patients to request a copy of their own medical records as well as requesting records from a patient's previous medical provider.

Last Name ____________________ First Name ____________________

Date of Birth ____________________ Phone Number ____________________

Request Statement (Check One)

All Medical Records

All billing records including all statements, itemized bills, and payment or denial of benefits.

All billing records including all statements, itemized bills, and payment or denial of benefits.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug use. I authorize the release or disclosure of this type of information.

I understand the following:

A. I have a right to revoke this information in writing at any time, except to the extent information has been released in reliance upon this authorization (Please see the Notice of Privacy Practices).

B. The information released in response to this authorization may be re-disclosed to other parties.

C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

Patient Signature, or Legally Authorized Representative with Title ____________________ Date

ROI - (Release of Information from Previous Provider)

I authorize: ____________________

Previous Provider Facility/Name

Delivery Information (Check One):

I prefer to pick up my Records.

Please mail or fax my records to **Luz Family Medical and Wellness Practice, LLC**
Fax: 541-526-1655
Address: 580 5th Street, Suite 500, Brookings, OR 97415

Right of Access Form for Family Member/Friend (optional)

I, ____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

_______________________________________ _______________________________________
First and Last Name Relationship

____
Phone Number

Health Information to be disclosed upon the request of the person named above:
(Circle either A or B):
A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
Mental Health Records
Communicable Diseases (including HIV and AIDS)
Alcohol/Drug Abuse Treatment
Other (please specify): ____

____

Form of Disclosure:
An electronic record or access through an online portal.
Hard copy
Verbal

This authorization shall be effective until (Check one):
All past, present, and future periods, OR
Date or event: ____
Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

____ ____________________________
Name of the Individual Giving this Authorization: Date of birth

____
Signature of the Individual Giving this Authorization:

Practice Financial Agreement Policy

Luz Family Medical and Wellness Practice, LLC
580 5th Street, Suite 500, Brookings, OR 97415

The Following is our financial agreement statement: please read, agree and sign. Patients and guardians are financially responsible for all charges regardless of third-party involvement. Patients with insurance are required to pay all out of pocket expenses at the time of service or make arrangements in advance.

Patient Responsibilities:

1. Provide Accurate Information: Provide complete and accurate information about your medical history, mailing address, health insurance and all other billing information. If any information changes, you need to inform Luz Family Medical Practice, LLC immediately. Patients will be held financially responsible for all insurance denials. It is the patient's responsibility to specify what type of initial exam they'd like (such as a New Patient Evaluation or Medicare Subsequent Annual Visit).
2. Patients are responsible for understanding their insurance benefits and referral requirements as well as for any co-pays, deductibles, premiums, and secondary insurance benefits.
3. Cash Pay: Patients without insurance coverage need to pay in full, at the time of service or make payment arrangements with the provider in advance.

____ _______________________

Patient Signature, or Legally Authorized Representative with Title Date

____

Patient Name, or Legally Authorized Representative with Title

Cancellation and No-Show Policy

If you need to cancel your appointment, please give us 24 hours notice. Patients with missed or canceled appointments without 24 hours notice will be charged $20 to their accounts. **THREE** no-shows or cancellations will result in the patient having to schedule same day appointments or having to wait for opening, as this interferes with the continuity of care.

____ _______________________

Patient Signature, or Legally Authorized Representative with Title Date

____

Patient Name, or Legally Authorized Representative with Title

Communication Policy

This office offers communication with providers and staff via phone calls and patient onboarding through our EMR. Reminder calls are done the day prior by staff to confirm appointments. Patients can opt to get text messages and emails to remind them of their upcoming appointments, that can be set through patient onboarding. Emailing with providers and staff is **NOT** an option due to email not being secure and **HIPPA compliant**. Please see office staff to set up patient onboarding.

Cell Phone Number for text message reminders: ____

Email Address for setting up patient onboarding and reminders: _________________________________

Do you wish to set up patient onboarding? Yes No

____ ___________________________

Patient Signature, or Legally Authorized Representative with Title Date

____

Patient Name, or Legally Authorized Representative with Title

Demographics

________________________________ ________ ____________________

First Name **Middle Initial** **Last Name**

_____/_______/__________ ______________________________

Date of Birth **Phone Number**

____

Previous or Birth Names

____

Physical Address

____

Mailing/Billing Address (If different then above)

Mobile Phone: ______________________ **Home Phone:** ____________________________

Email: ____

Social Security Number: ____

Pharmacy: ____

Sex (Circle One): Male Female Intersex Other/Prefer not to specify

Gender Identity: ____

Preferred Language (Verbal and Written):

____

Preferred Communication Method: Home Phone Cell Phone Patient Onboarding

Race (Circle One): White African American or Black Asian Decline to Specify

American Indian/Alaska Native Native Hawiann or Other Pacific Islander Other Race

Ethnicity (Circle One): Hispanic/Latino Not Hispanic/Latino Decline to Specify

Sexual Orientation (Circle One): Heterosexual (straight) Lesbian/Gay Bisexual Other

Unknown Decline to Specify

Marital Status (Circle One): Single Married Widowed

Spouse: __________________________________ Contact Info: __________________

First and Last Name Phone Number

Emergency Contact:____________________________________ __________________

Full Name Phone Number

Insurance Information (This information is Needed to Schedule):

Please bring in a copy of your insurance card when you turn in your packet.
Cash Pay (Circle One): Yes No

Primary Insurance:

Company: ____________________ ID Number: ____________________

DBN/Benefits Number (Tricare Only): ____________________

Group Number: ____________________ Effective Date: ____________________

Secondary Insurance:

Company: ____________________ ID Number: ____________________

Group Number: ____________________ Effective Date: ____________________

Responsible Party:

____________________ ____________________
First and Last Name Relationship to Patient

____________________ ____________________

Patient Signature, or Legally Authorized Representative with Title Date

____

Parent/Guardian, or Legal Authorized Representative with Title

HIPAA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review Luz Family Medical Practices Notice of HIPAA Practices for protected health information.

____________________ ____________________

Patient Signature, or Legally Authorized Representative with Title Date

____

Parent/Guardian, or Legal Authorized Representative with Title

Comprehensive Health History Questionnaire

Your answers on this form will help the provider get an accurate history of all medical concerns and conditions. Please take time to fill out every question to the best of your ability so that we can provide you with the best care possible.

Main Reason for your visit: ____

____

Other Concerns: ____

____

*Please keep in mind that the provider can only cover a certain number of concerns per visit in order to give you good and detailed care.

Other Specialists: ____

____

Allergies or intolerance (Circle One): Yes No

If yes, to what and the reaction: ____

____

Medications

Please list all medications that you are on as well as their dosages and how many times you take them per day. (Prescribed and over the counter medications). **This form is necessary for scheduling and prescribing.**

I take no prescription and non-prescription medications

Medication	Dosage	Frequency

Immunizations (Check ALL that apply):

Tetanus Td)
Tetanus with pertussis (Tdap)
Varicella (Chicken Pox) Shot or Illness
Pneumonia
Flu Shot
Hepatitis A
Hepatitis B
MMR
Meningitis
Shingles
HPV
Covid - 19

Health Maintenance Screening

Lipid (Cholesterol): ____________________________Date: ________________ Results:_____________

Colonoscopy: __________________________________ Date: _______________ Results: _____________

Mammogram: _________________________________ Date: _______________ Results: _____________

Pap Smear: ___________________________________ Date: _______________ Results: _____________

Personal Medical History:

Check off the Now/Past Box if the following applies to you:

- No History of significant illnesses/conditions

Condition	Current	Past	Comments
Alcohol/Drug Abuse			
Seasonal Allergies			
Anemia (*Cause if known)			
Anxiety			
Arthritis (*Location)			
Rheumatoid Arthritis (*Location)			
Osteoarthritis (*Location)			
Asthma, Not limiting			
Asthma, Limiting Activity			
Bladder Problems			

Blood Clot (Leg)			
Blood Clot (Lung)			
Blood Transfusion			
Benign Breast Lump			
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Prostate Cancer			
Cancer (Other type- specify)			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Type II Diabetes			
Type I Diabetes			
Diverticulosis			
Other Gynecological Condition			
Emphysema (COPD)			
Fractures (*Location)			
Glaucoma			
Gallbladder Disease			
HeartBurn/GERD			
Gout			
Endometriosis			
Fibrosis			
Heart Attack			

Hepatitis A			
Hepatitis B			
Hepatitis C			
Other Hepatitis			
High Blood Pressure			
High Cholesterol			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Irritable Bowel Syndrome			
Migraines			
Osteoporosis			
Pneumonia			
Prostate Enlargement			
Prostate Nodules			
Seizures/Epilepsy			
Eczema			
Psoriasis			
Abnormal Moles			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid Nodule			
Hyperthyroidism (Overactive)			
Hypothyroidism (Underactive)			

Other condition not listed: ____

Surgical/Procedure History:

- I haven't had any surgeries or medical procedures.

Procedure	Yes/No	Year/Comments
Abdominal Surgery		
Angiogram (Heart)		
Angiogram (Vascular)		
Appendectomy		
Back Surgery (Lumbar)		
Biopsy (*Location)		
Breast Biopsy		
Breast Surgery		
Cataract Surgery		
Coronary Bypass		
Coronary Stent		
C-Section		
Echocardiogram (Heart)		
EGD (Stomach Endoscopy)		
Gallbladder Removal		
Other Heart Surgery		
Hip Surgery		
Hysterectomy (Partial)		
Total Hysterectomy		
Knee Surgery		
LEEP (Cervix Surgery)		
Neck (Spine) Surgery		

Ovary Removal		
Pulmonary Function Test		
Sinus Surgery		
Stress Test (Echo)		
Stress Test (Thallium/Perfusion)		
Stress Test (Treadmill)		
Tonsillectomy		
Tubal Ligation		
Vasectomy		

Other Surgeries/Procedures not listed above: ____

____

____

Family History

Adopted (Circle One): Yes No

	Mother	**Father**	**Sister (s)**	**Brother (s)**	**Mom's Mom**	**Mom's Dad**	**Dad's Mom**	**Dad's Dad**	**Comments**
Alive									
Deceased									
Age Currently or at Death									
No significant history is known									
Hypertension									
High Cholesterol									
Heart Attack, Coronary Artery Disease									
Type II Diabetes									
BreastCancer									
Colon Cancer									
Prostat Cancer									

	Mother	Father	Sister (s)	Brother (s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Comments
Osteoporosis									
Depression									
Alcoholism/Drug Abuse									
Alzheimers									
Asthma									
Autoimmune Disease									
Bleeding or clotting disorder									
Lung Cancer									
Ovarian Cancer									
Other type of cancer									
Colon Polyp									
Type I Diabetes									
Emphysema (COPD)									

	Mother	**Father**	**Sister (s)**	**Brother (s)**	**Mom's Mom**	**Mom's Dad**	**Dad's Mom**	**Dad's Dad**	**Comments**
Genetic Disorder (*Explain)									
Glaucoma									
Heart Disease (CHF)									
Hepatitis B or C									
Hip Fracture									
Hypothyroidism									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Stroke									
Sudden Cardiac Death									

Social History

Tobacco Use:

Current Smoker (Circle One): Yes No

Former Smoker (Circle One): Yes No Quit Date: ____________________________

How Many Packs per day: ______________ How many Years did you smoke: ___________________

Chew User (Circle One): Yes No How many years: ___________

Are you ready to Quit (Circle One) Yes No

Alcohol Use:

Do you drink Alcohol (Circle One): Yes No # of drinks per week: ______________________

Drug Use:

Do you use any recreational drugs (Circle One): Yes No Recent use (Circle One): Yes No

If yes, which ones: ____

____

How much Caffeine do you consume daily: ____

How would you describe your diet:

- General
- Vegan
- Low Sodium
- Low Fiber
- Low Cholesterol
- Other: ______________________________________

Sexual Activity:

Are you sexually active (Circle One): Yes Never Not Currently

Birth Control/STD Prevention (Circle all that apply):

Condom IUD Pill Ring Patch

Tubal Ligation Vasectomy Other: ____

Do you exercise regularly (Circle One): Yes No

Place of Business: ____

Exposure of toxic chemicals (Circle One): Yes No

If yes, where and to what: ____

Medical Forms (Which have you completed):

- Advanced Directive for Health Care
- Durable Power of Attorney for Healthcare
- Decisions
- Living Will
- POLST
- Know about forms, haven't completed any.
- Do not know what these are.

Depression Screening:

In the past two weeks have you been feeling down, depressed, or hopeless? Yes No

Do you have little interest or pleasure in doing things? Yes No

Anything else our provider should know: ____________________________________

____

____