LIMA
Lubbock Integrative Medical Associates
www.limalubbock.com

4002 22nd Street Lubbock, Texas 79410
info@limalubbock.com
(806) 795-1393 FAX: (806) 722- 3185

DATE:			**ACCT:**	
PATIENT: LAST NAME		**FIRST NAME**		**MIDDLE NAME**
MAILING ADDRESS		**CITY, STATE**		**ZIP**
SEX	**BIRTHDATE**	**SOCIAL SECURITY NUMBER**	**AGE**	**HOME TELEPHONE**
EMAIL ADDRESS				**CELL TELEPHONE**
WORK PHONE/ADDRESS		**CITY, STATE**		**ZIP**

PATIENTS STATUS: A) ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED**
B) ☐ **EMPLOYED** ☐ **FULL TIME STUDENT** ☐ **PART TIME STUDENT**

PATIENTS RELATIONSHIP TO INSURED: ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER**

WORK RELATED INJURY? ☐ YES ☐ NO **DATE OF INJURY:**

PRIVATE OR GROUP INSURANCE

ARE YOU A MEMBER OF A MANAGED CARE PLAN? (PPO, HMO, ECT.?) ☐ YES ☐ NO

NAME OF PRIMARY (FIRST) INSURANCE COMPANY				
POLICY NUMBER		**GROUP NUMBER**		**GROUP NAME**
INSURANCE COMPANY ADDRESS		**CITY/STATE**		**ZIP**
POLICY HOLDERS LAST NAME		**FIRST NAME**		**MIDDLE NAME**
SEX	**BIRTHDATE**	**SOCIAL SECURITY NUMBER**	**AGE**	**HOME TELEPHONE**

MEDICARE SUPPLEMENTAL OR ADDITIONAL INSURANCE COMPANY

NAME OF SUPPLEMENTAL OR SECONDARY INSURANCE COMPANY				
POLICY NUMBER		**GROUP NUMBER**		**GROUP NAME**
INSURANCE COMPANY ADDRESS		**CITY/STATE**		**ZIP**
POLICY HOLDERS LAST NAME		**FIRST NAME**		**MIDDLE NAME**
SEX	**BIRTHDATE**	**SOCIAL SECURITY NUMBER**	**AGE**	**HOME TELEPHONE**

WHAT DOCTOR REFERRED YOU TO OUR OFFICE?

NAME:		**PHONE NUMBER:**
PERSON TO CALL IN EMERGENCY:	**RELATIONSHIP:**	**TELEPHONE:**
PRIMARY CARE PHYSICIAN:		

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NURSING ASSESSMENT

Please complete this short questionnaire so that we can evaluate your current condition and speed your visit with the doctor. Thank you for your cooperation.

NAME: _____
(FIRST) (MIDDLE) (LAST)

REFERRING PHYSICIAN: _____

REASON FOR SEEING THE DOCTOR TODAY: _____

Have you had recent tests (x-rays, blood tests, etc.) for this particular condition? ☐ Yes ☐ No

Name of Test	Date of Test	Place of Test

Do you have a written report with you? ☐ Yes ☐ No
Do you have x-ray films with you? ☐ Yes ☐ No

PLEASE CIRCLE ONE ANSWER FOR EACH:

RACE: Asian * Black/African American * American Indian/Alaska Native * White * Hispanic * Indian/India * More than 1 Race * Refused
ETHNICITY: Hispanic or Latino * Non-Hispanic or Latino * Refused to Report
LANGUAGE: ASL * Arabic * Chinese * English * French * German * Indian * Japanese * Spanish * Vietnamese * Other

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Due to a federal Government mandate, we are now required to send you an email offering you the opportunity to communicate with us via an online patient portal.

Please note: you will only receive one e-mail from us inviting you to join this portal. Once you get this email, you can either elect to join or decline the offer.

Thank you in advance for helping us comply with this federal mandate by suppling us with your email address. Please keep the instruction on the next page to help setup your RXNT Patient Portal.

Name: _____

Email: _____

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Follow RXNT Patient Portal Setup – New Participant

When you provide us with your email address, we will send you and invitation to join the RXNT Patient Portal on line. Your invitation will be waiting for you in your email inbox.

Click the blue "Click Here" link to begin your registration

You will be taken to the LIMA Lubbock registration page.

Select "Sign up and connect" and follow each of the following steps"

Step 1: Create your user name and password

Step 2: Accept Terms of Service

Step 3: Enter your invite code *The pin # that you were given*

Step 4: Accept release of information *This is the same HIPPA form you signed with your patient paperwork*

Step 5: Upload health record *This will start automatically*

Once you are signed in, please click on INBOX and the COMPOSE.

Select your provider and send a test message.

This step is important as our staff will use this test message to be sure your account is functioning.

Thank you for your cooperation!!

*If you need help with any portion of the account setup, please see the front desk and they can assist you. *

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New Patient Information Form

Patient Name: _____ Chart #: _____Age: _____ Wt: _____ Temp: _____

Date: _____ Referring Physician: _____ BP: _____/_____ Pulse: _____

History: Chief Complaint:

_____

HISTORY of PRESENT ILLNESS: *For an "Extended" history, document at least 4 of these elements

- Location (Where is the pain/problem?)
- Quality (Example: Sharp, dull, ache, burning, cramping)
- Severity (How severe is the pain/problem)
- Duration (How long have you had this pain/problem? Or when did it start?)
- Timing (Does this pain/problem occur at specific times?)
- Context (What were you doing at the onset of this pain/problem?)
- Associated signs/symptoms (What other associated problems have you been having?)
- Modifying Factors (What makes the pain/problem worse or better? Or Have you had any previous episodes?)

Medical History: *For a "Pertinent" history – at least 1 specific item for ANY ONE of the 3 histories
*For a "Complete" history – at least specific item for EACH ONE of the histories

- **Patient Medical History**

Diabetes…… ☐ No ☐ Yes
(If yes: Diet Pills Insulin)
Hypertension …….. ☐ No ☐ Yes
Cancer …… ☐ No ☐ Yes
(if yes, what organ(s) _____)
Stroke…… ☐ No ☐ Yes
Heart trouble …… ☐ No ☐ Yes
(if yes: Heart Attack, Arrhythmia, Heart Failure, Bypass)
Arthritis/gout ……... ☐ No ☐ Yes
Convulsions …… ☐ No ☐ Yes
Bleeding Tendency…… ☐ No ☐ Yes
Acute infections…… ☐ No ☐ Yes
Venereal Disease……. ☐ No ☐ Yes
Hereditary defects……. ☐ No ☐ Yes

- **Family History**

Diabetes: _____ Relationship: _____
Heart Disease: _____ Relationship: _____
Cancer: _____ Relationship: _____
Stroke: _____ Relationship: _____
Alzheimer's : _____ Relationship: _____
Other: _____ Relationship: _____

- **Patient Social History**

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Use of tobacco: ☐ Never ☐ Previously, but quit _____ ☐ Current packs/day _____
Use of drugs: ☐ Never ☐ Type/Frequency _____
Excessive exposure at home or work to: Fume ____Dust _____Solvents _____Air-Borne particles ____ Noise ____

PREVIOUS SURGERIES	DATE	DR. WHO PREFORMED SURGERY OR HOSP

CONSTITUTIONAL SYMPTOMS		
Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes
EYES		
Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes
EARS / NOSE/ MOUTH/ THROAT		
Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes
CARDIOVASCULAR		
Heart Trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles, or hands	No	Yes
	No	Yes
RESPIRATOR		
Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
GASTROINTESTINAL		
Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach)	No	Yes
GENITOURINARY		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male – testicle pain	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes
Female - # pregnancies #miscarriages	No	Yes
Female – date of last pap smear	No	Yes

MUSCULOSKELETAL		
Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty walking	No	Yes
INTEGUMENTARY (skin, breast)		
Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes
	No	Yes
NEIROLOGICAL		
Frequent or recurring headaches	No	Yes
Light headed or dizziness	No	Yes
Convulsion or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes
PSYCHIATRIC		
Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
ENDOCRINE		
Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes
HEMATOLOGIC/ LYMPHATIC		
Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

Long Term Medication Summary

PATIENT NAME: _____ MEDICAL RECORDS #: _____

ALLERGIES / DRUG REACTION: _____

DOB: _____ PREFERRED PHARMACY: _____

MEDICATIONS / DOSAGE / FREQUENCY / QUANITY

Authorization to disclose health information

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Social Security number: _____

I authorize Lubbock Integrative Medical Associates, 4002 22nd St Lubbock TX 79410

TO disclose the above-named individual's health information:

This information may be disclosed to and used by the following individual or organization, Lubbock Integrated Medical Associates, 4002 22nd St Lubbock TX 79410

_____Address: _____

For the purpose of _____

Please release the following:

_____ Problem List
_____ Progress Notes
_____ History/Physical Exam
_____ Medication List
_____ Immunization Record
_____ List of Allergies
_____ X-Ray/Imaging Reports - from (date) _____ to (date) _____
_____ XC-Ray Films
_____ Laboratory Results - from (date) _____ to (date) _____
_____ EKG Reports
_____ Other Diagnostic Reports (Specify) _____
_____ Other (Specify) _____

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 services, and treatment for alcohol and drug abuse.
_____ YES, I consent to the release of this information. _____ NO, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Lubbock Integrative Medical Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

Lubbock Integrative Medical Associates
Time-of-Service Payment Policy

Thank you for choosing Lubbock Integrative Medical Associates to care for you. We are committed to providing our patients quality and affordable healthcare. This policy is intended to help our patients understand our payment expectations.

- LIMA will not file a claim to your insurance. However, we will provide you with the necessary information required for you to file your insurance for reimbursement. The full payment will be due at the time of service and must be collected at your visit. We accept cash, check, VISA, Master Card, American Express and Discover.

- Patients will be subject to a $35 fee for any payment that is returned for NSF, declined, or a disputed payment.

- LIMA will NOT verify benefits and eligibility for any patients prior to their visit. As we do not accept insurance as a form or a guarantee of payment.

- Patients may be asked to pay a deposit prior to their visit.

- Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24hr. notice of cancellation to avoid a cancellation fee. More than 2 reschedules of the same appointment will be subject to the same fee as a cancellation.
- Patients are expected to pay previous account balances in full prior to their next visit.

- It is the patient's responsibility to know his/her insurance benefits and that we will only provide the documentation for the patient to file with their insurance privately.

- It is the patient's responsibility to obtain a referral, if needed, prior to the visit.

- Lubbock Integrative Medical Associates does not allow payment plans of any kind.

- If your balance remains unpaid, we may refer your account to a collections agency.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Patient Signature Date

Lubbock Integrative Medical Associates
Patient Consent Form

Patient Name: _____ DOB: _____

Please
Initial

_____ **Patient Reminder**
Phone call: (select one) [☐]
E-Mail address: _____ (If left blank = declined)
Text message: [☐]

_____ **Acknowledgement of Receipt of Notice of Privacy Practices**

I have been presented with a copy of the **Lubbock Integrative Medical Associates** Notice of Privacy Policy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, outlining my rights regarding my Health information.

_____Consent for LIMA Lubbock to disclose my private health information

I consent to Lubbock Integrative Medical Associates employees disclosing my private health information such as test results and billing information with a designated family member or personal representative.

Name:_____Relationship:_____
Address:_____
Phone number(s):_____

Name:_____Relationship:_____
Address:_____
Phone number(s):_____

Name:_____Relationship:_____
Address:_____
Phone number(s):_____

_____ _____
Signature of Patient or Patient's Representative Date

_____
Relationship to Patient

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No Show Policy

This letter is to notify you effective January 1, 2020 you will be charged $45.00 for not showing up for your appointment.

The deposit for the initial visit in non-refundable, a no show/no call for the initial visit will cost you the $200 deposit.

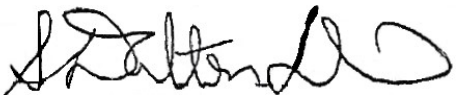
Cancellation without 24-hour notice will result in a $45.00 fee.

We do our best to contact you the day before your appointment and remind you so that you have the option to cancel or reschedule.

For repeated non-compliance with follow up appointments termination of care will be considered.

If you have any questions, please let me know.

Sincerely,



Stephen G. Dalton DO

_____ _____

Patient Signature and Date Printed Name of Patient