LIMA
Lubbock Integrative Medical Associates
w w w . l i m a l u b b o c k . c o m

**Our Commitment to You**

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.
- In order to give you as much notice as possible, we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.
- If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

**General Information**

- Our office hours are very limited. It is very important that your keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.
- We are sorry, but due to the high fax volume we are NOT able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
    1. Photo ID
    2. MRI films and reports, CT scan films and reports, bone scan reports
    3. EMG reports
    4. Primary doctor’s notes, other specialists’ notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, oncologists, infectious disease physicians, etc.)
    5. List of current medications

**Financial Policy**

- We are committed to providing you with the best possible care.
- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in full at the time of service, unless you have made payment arrangements in advance with our business office.

Returned checks will be subject to **an additional $35 service fee**

**Missed Appointments**

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 48 hours in advance,** our policy is to charge a **NO SHOW FEE** for missed office appointments.

**I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for this account. I further agree to pay any attorney's fee, court cost, and related collection fees that incurred if there is issues with payment.**

_________________________________ X _________________________ __________

Patient Name Signature Date

## Ketamine Infusion Therapy Disclaimer

I wish to participate in Ketamine Infusion Therapy at LIMA Lubbock. I understand and acknowledge that Ketamine Infusion Therapy will **NOT** be covered by either federal or private payors and that my personal healthcare insurance will **NOT** cover Ketamine Infusion Therapy. Thus, I agree **NOT** to make a claim for Ketamine Infusion Therapy with my personal healthcare insurance carrier and further agree and acknowledge that I must pay by cash, check or major credit card all related healthcare costs related to the Ketamine Infusion Therapy at LIMA Lubbock.

By signing below, I accept and acknowledge that **I am opting out** of using my healthcare insurance for the Ketamine Infusion Therapy and accept paying cash, check or major credit card for these services.

**I understand clearly that Ketamine infusion therapy is NOT FDA approved.**

Acknowledged and accepted by:

______________________________________________________

Patient Signature

# Patient Information and History

**Last Name: ________________________First Name: _________________________ SEX: M F**

**If patient is a minor, name of parent or guardian accompanying patient: _______________________**

**Relationship to patient: ________________________Phone # (if different): _____________________**

**Address: ____________________________________________________________________________**

**City: ___________________________________ State: _____________________ Zip Code: ________**

**Home Phone: ____________________________ Cell Phone: __________________________________**

**Email: ______________________________________________________________________________**

**Date of Birth: ____________________________ SS#: _______________________________________**

**(Circle one) Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other ◯**

**Referred by: ___________________________ Phone: ___________________Location: ___________**

**Family Doctor: _________________________ Phone: ___________________Location: ___________**

**Emergency Contact: ____________________________________Phone: ________________________**

**Are we authorized to release your medical information to the listed emergency contact? Yes or No**

**SIGNATURE: ______________________________________________ DATE: _________________**

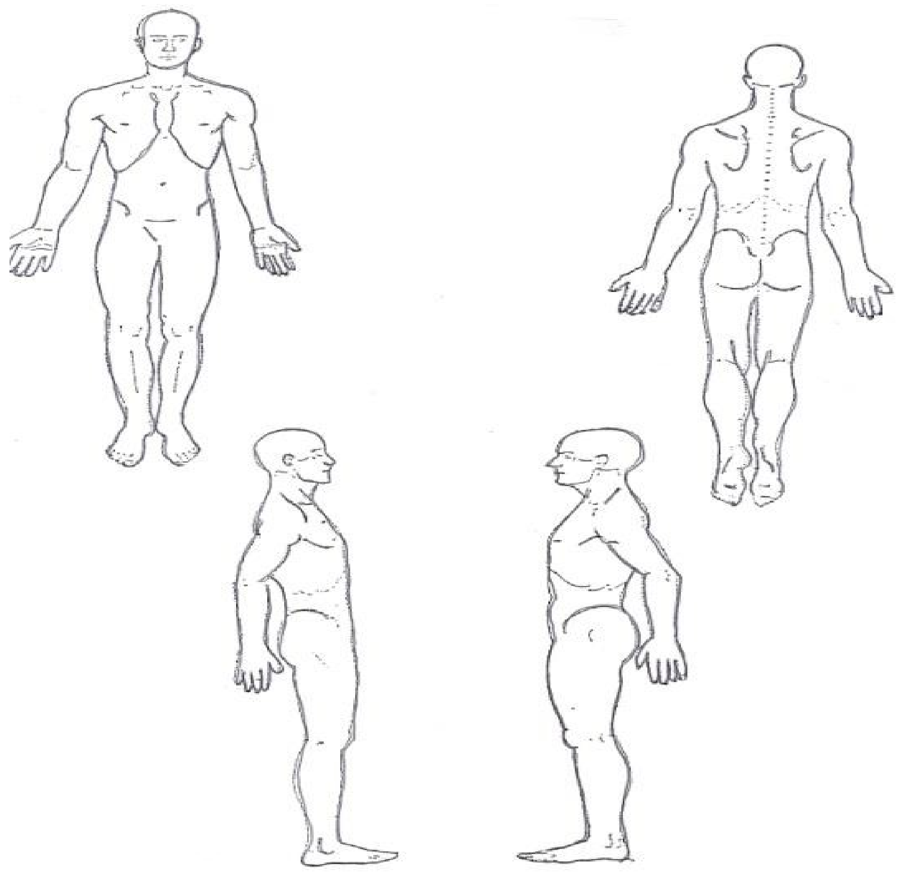
• Today's date: _____________ Name: ___________________________________________________

• Age___________ Date of Birth ____________________ Height __________ Weight ___________

□ Right hand dominant □ Left hand dominant  Sex: □ Male □ Female

**Referral Physician: ___________________________Primary Care Physician: ____________________**

**Chief Complaints;**



4002 22nd Street, Lubbock Texas 79410
www.limalubbock.com (806)795-1393 info@limalubbock.com

• Current Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Average Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Location ____________________________________________________________

____________________________________________________________________

____________________________________________________________________

• Does the pain radiate anywhere (“shooting down” or “shooting up”)?
•
• When did the pain start? ____________________________________________________

____________________________________________________________________

• How did the pain start? _____________________________________________________
•
____________________________________________________________________

• Please, describe your pain:
□ Dull □ Aching □ Sharp □ Shooting □ Stabbing □ Throbbing □ Numbness □ Burning

---

▯ How often is your pain present? □ Occasional □ Frequent □ Constant ▯ Worst time of day?
□ Morning □ Afternoon □ Evening □ Night □ All the time ▯ Any color change or temperature change? ________________________________________

▯ Numbness in anywhere? __________________________

▯ “Pins and needles”? ________________________________________

▯ Weakness? (Right leg, right arm, both legs….) ______________________

▯ Swelling? ______________________________________________

▯ What makes symptoms worse/exacerbate? __________________________
□ Walking □ Standing □ Lying down □ Sitting □ Bending forward □ Bending backward □ Driving
□ Coughing □ Bowel movement □ Cold weather □ Hot weather □ Rainy day □ Lifting objects

□ "Injections" □ Sleeping □ Medication (Names) ___________________ □ Other ___________________

- Sleeping: □ Well □ "OK" □ Terrible □ 2 hrs. □ 4 hrs. □ 6 hrs. □ 8 hrs. □ >10 hrs.

- How often do you wake up at night? □ 0 □ 1 □ 2 □ 3 □ 4 □ >5 times Previous Treatments

Physical therapy □ Location ______________________ □ Date of Last PT ______________ □ Duration ______________

Acupuncture ________________________ Psychotherapy ______________________________

Chiropractor ______________________ Other (Biofeedback, Meditation, Yoga, Swimming)

TENS Unit □ Never used □ I have a unit □ I don't have one □ Used at home daily □ Used

**Review of System**

- Gen □ Weight loss □ Weight gain □ Fever □ Fatigue □ Loss of appetite □ Nausea □ Vomiting
- Skin □ Skin problem □ Rash □ Psoriasis □ Slow healing □ Easy bruising □ Itching
- Neuro □ Light headed/dizziness □ Fainting □Weakness □Stroke □ Tremor □ Seizure □ Memory loss
- Eyes □ Vision problem □ Glaucoma □ Blurred vision □ Double vision
- ENT □ Ear pain □Hearing loss □Ear noises □Nose bleed □Sore throat □Hoarseness □Dental issues
- Cardiovascular □ Chest pain □Chest pressure □Shortness of breath □Irregular heart beat □ Murmurs
- Respiratory □ Coughing □ Difficulty breathing □ Asthma/Wheezing □ Coughing up blood
- Gastrointestinal □ Constipation □ Diarrhea □Heartburn □Bloody stool □Pain in stomach □Ulcers □Hepatitis
- Genitourinary □ Painful urination □Frequent urination □Bloody urine □Kidney stone □Incontinence □ Sexual difficulty □ Infection
- Endocrine □ Hypothyroidism □ Hyperthyroidism □ Diabetes □ Parathyroid problems
- Hematology □ Anemia □ Bleeding disorder □ Easy bleeding □ Lymphoma/Leukemia □ Sickle cell disease
- Immunologic □ Catch cold easily □ HIV/AIDS □ Fever □ Hay fever □ Frequent sinus problems
  - □ Allergies
- Musculoskeletal □ Arthritis □Rheumatoid arthritis □Osteoarthritis □Compression fracture □Head injury
  □ Neck injury□ Lower back injury □ Spinal trauma □ Birth trauma □ Birth defect □ Lupus
  □ Spina bifida □ Gout □ Osteoporosis □ Muscular dystrophy □ Muscle pain □ Scoliosis
- **Women only** □ Irregular periods □ Premenstrual depression □ Hot flashes □ Menstrual cramps
  □ Vaginal discharge □ Hysterectomy □ Breast surgery □ Nipple discharge □ Breast lumps
  □ Last mammogram ___________

- **Men only** □ Burning on urination □ Dripping after urination □ Prostate problems □ Difficulty urinating
- Psychiatric □ Depression □ Anxiety □ Panic attacks □ OCD □ Manic □ Bipolar □ Suicidal attempts
  □ Suicidal ideation □ Homicidal □ Hallucination □ Psychosis □ Other _______________

## Past Medical History

- **Heart** ☐ Coronary artery disease ☐ Hypertension ☐ Murmurs ☐ Valvular disease ☐ Aneurysm ☐ High cholesterol ☐ Pacemaker ☐ Deliberator ☐ Heart failure ☐ Angina ☐ Other _______________
- **Lungs** ☐ Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia ☐ Lung cancer ☐ Other _________
- **Gastrointestinal** ☐ Ulcer ☐ Reflux ☐ Gastritis ☐ Hepatitis ☐ Cancer ☐ Bleeding ☐ Diverticulosis ☐ Other _____________
- **Kidney** ☐ Failure ☐ Stones ☐ Dialysis (When) _____________ ☐ Other ________________
- **Endocrine** ☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other _______________
- **Neuro** ☐ Stroke ☐ Aneurysm ☐ Brain cancer ☐ Nerve injury ☐ Spinal cord injury ☐ Alzheimer's ☐ Dementia ☐ Seizures ☐ Parkinson's ☐ Other __________
- **Psychiatric** ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Panic disorder ☐ Psychosis ☐ Schizophrenia ☐ Other ___________
- **Bone/Muscular** ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout ☐ Osteoporosis ☐ Scoliosis ☐ Other _________

- Cancer ☐ ______________________________________________________________________________

- Other ☐ ______________________________________________________________________________

## Past Surgery History

_______________________________________________________________________________________

_______________________________________________________________________________________

## Allergies

☐ Latex ☐ No ☐ Yes Reaction ______________ ☐ Contrast (Dye) ☐ No ☐ Yes Reaction _________

☐ Allergic to any medication(s)? ___________________________________________________________

_______________________________________________________________________________________

## Previous Medications (Tried previously but failed to relieve the symptoms & pain)

_______________________________________________________________________________________

_______________________________________________________________________________________

**Current Medications**

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Significant Family History** (Cancer, hypertension, diabetes, depression, back pain…)

- Father side ______________________________________________
- Mother side ______________________________________________
- Siblings ________________________________________________

**Social History**

- Tobacco: ☐ Never ☐ Quit in ________ ☐ Currently ____ pack/ per day
- Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily_______________
- Use of drugs ☐ Never ☐ Occasionally ☐ Frequently, Type/frequency ____________
- Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
- Family status: Living with _______________________________________________
- Occupation: _______________________________________________
- Disability: ☐ No ☐ Yes (Type) ______________________

**This form is completed by**

☐ Patient X ___________________________________ Date _____________

# Authorization for Release of Information

Name of Patient ________________________________ Date of Birth _______________

LIMA Lubbock is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

**Entity to Receive Information Description of information to be released**
Check each person/entity that you approve to receive information.

Voice Mail

☐Results of lab tests/x-rays
☐ Other______________________________________________________________

Spouse (provide name & phone number) ___________________________________________

☐ Financial
☐ Medical as follows____________________________________________________

Parent (provide name & phone number) __________________________________________

☐ Financial
☐ Medical as Follows____________________________________________________

Other (provide name & phone number) ______________________________________

☐ Financial
☐ Medical as Follows____________________________________________________

**Patient Information**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient

_______________________________________________________ Date _____________
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)