

Dr. Thomas Wright

CONFIDENTIAL PATIENT RECORD

PATIENT INFORMATION										
First Name			Last Name				Middle Initial		Suffix	
Address			Date of Birth		Social Security Number		Gender			
			Phone		Alternate Phone			<input type="checkbox"/> Female	<input type="checkbox"/> Male	
City			Emergency Contact			Emergency Phone				
State		Zip	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other			<input type="checkbox"/> Employed <input type="checkbox"/> FT Student <input type="checkbox"/> PT Student				
Employer / School					Work Phone			Ext.		
					Email					
PRIMARY PAYOR INFORMATION										
Primary Payor Name					Phone		Fax			
Claim Submission Address					City		State	Zip		
PRIMARY POLICY INFORMATION										
Policy ID		Group Number (Required for BCBS)		Group Name			Policy Start Date	Policy End Date	Copay Amount	
Date of Injury (Required for MVA or WC)		Insured Party (if other than patient)			Insured Party DOB		Patient Relation to IPR (Required if other than patient)			
SECONDARY PAYOR INFORMATION										
Primary Payor Name					Phone		Fax			
Claim Submission Address					City		State	Zip		
SECONDARY POLICY INFORMATION										
Policy ID		Group Number (Required for BCBS)		Group Name			Policy Start Date	Policy End Date	Copay Amount	
Date of Injury (Required for MVA or WC)		Insured Party (if other than patient)			Insured Party DOB		Patient Relation to IPR (Required if other than patient)			
REFERRAL INFORMATION										
Referring Physician				Address						
Phone		Fax								
Email										
UPIN #				License #		City		State	Zip	

Authorization of Benefits

I request that payment of authorized Medicare/third party insurers benefits be made either to me or on my behalf to Dr. Thomas Wright for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or third party insurers or their agents any information needed to determine these benefits or benefits for related services.

PATIENT SIGNATURE

DATE

**Laser Lipo & Vein Center
Dr. Thomas Wright**

New Patient Questionnaire

Name: _____ **DOB:** _____ **Date:** _____
Main Reason for Visit: _____

Medical History

Please list any medical problems treated in the past (example: asthma, diabetes, heart disease, etc)

Problem	Year Started	Problem	Year Started

Surgeries	Year	Complications?

Medications/Vitamins/Herbs

Please list all medications and supplements you are currently taking. (Oral-topical-injection. Include any form of birth control, and all non prescription medications or and vitamins.)

Name	amount	how often

Social History

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
Occupation _____
Have you ever used tobacco? Y N If yes, how much _____ And for how long _____
Current use Y N How much _____ Have you ever considered quitting? Y N
Do you drink Alcohol? Y N If yes, how much _____ What kind _____
Have you ever used street drugs? Y N If yes, please explain _____
Are you on a low fat or weight loss diet? Y N
Do you exercise on a regular basis? Y N What kind of exercise? _____ How often _____
Do you consume caffeinated beverages? Y N Number of cups (8oz) of coffee or soda per day _____
Number of sexual partners in the last year? _____

Patient's Signature: _____ **Reviewed By:** _____ **Date:** _____

Patient's Name _____

Do you have any medical allergies? Y N If yes, please list below.
(examples: aspirin, penicillin, sulfa, codeine, local anesthetics, antibiotic ointments, latex, etc.)

Allergies:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had problems with general/local/regional anesthesia? Y N

Have you had any problems with Herpes virus? Y N

Have you taken Zovirax, Famavir, or Valtrex? Y N

Are you or have you ever been treated for acne? Y N

Are you currently on any acne treatment? Y N

Have you ever taken Accutane or oral antibiotics for acne? Y N

Have you ever tested positive for HIV? Y N

Do you wear sunscreen regularly? Y N

Do you sunbathe or tan artificially? Y N

Have you had recent sun exposure? Y N

Family History

	Age	Health Problems	Age at death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Children	_____	_____	_____	_____
Other important family medical history	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Patient's Name _____

Symptoms

(Please check the symptoms you have recently experienced)

General

- Fatigue
- Fever
- Chills
- Weight loss/gain
- Night sweats

Cardiovascular

- Chest pain
- Fainting/blackouts
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Rapid heart beat
- Shortness of breath
- Swelling of ankles

Respiratory

- Persistent cough
- Shortness of breath
- Wheezing
- Sputum production
- Asthma history

Leg Veins - Symptoms

- Swelling Prominent
 - Ropy Spider veins
 - Tender or hard veins
 - Aching Burning
 - Itching Tired
- Skin Changes
- Browning
 - Reddening

How long have you had these symptoms? _____

What makes the symptoms worse? _____

Standing long periods of time? Y N

Does anything help relieve the symptoms? _____

Elevation? Y N

Do you wear support stockings? Y N

Have you ever? Y N

Did it improve your symptoms? Y N

Any history of blood clots? Y N

Phlebitis? Y N

Gastrointestinal

- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Rectal bleeding

Genitourinary

- Painful urination
- altered sex function
- previous venereal dz
- sore on genitals

Musculoskeletal

Pain, weakness, numbness

- Arms Hips
- Back Legs
- Feet Neck
- Shoulders Hands

Skin

- Rash
- Dryness
- Changes in moles
- Sore that won't heal
- Acne
- Rosacea
- History or concerns of Skin cancer

Endocrine

- Excessive thirst
- Excessive hunger
- Excessive urination
- Cold intolerance
- Diabetes
- Thyroid disease
- Polycystic Ovarian Syndrome

Hematological

- Bleeding problems
- Easy bruising
- Anemia

Allergy/ Immune

- Hay fever
- Hives
- Allergic reaction/s

Are you interested in any other services?

- Acne treatment
- Botox or Restylane
- LipoDissolve
- Laser Hair Removal
- Photo-rejuvenation
- Sclerotherapy
- Laser Vein Treatment
- Weight management with Take Shape for Life

How did you hear about us? _____ May we thank them? Y N

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Use and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission. We may use and disclose PHI about you so that the treatment and services you receive at our practice may be billed and payment collected from you, an insurance company or a third party. We may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you regarding your appointments or send notification by mail of test results.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as Required by Law; Communicable Diseases; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Workers' Compensation: We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object Unless Required By Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your PHI.

You Have the Right to Inspect and Copy Your PHI: You have the right to inspect and copy your PHI that may be used to make decisions about your care. Usually, this includes medical and billing records, under Federal law; however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and Protected Health Information that is subject to law that prohibits access to PHI.

To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying (including labor), mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

You Have the Right to Request a Restriction of Your Protected Health Information: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You Have the Right to Request to Receive Confidential Communications from us by Alternative Means or at an Alternative Location. You Have the Right to Obtain a Paper Copy of This Notice From Us upon request.

You May Have the Right to Have Your Physician Amend your Protected Health Information. If we deny your request for amendment, you have the right to file a Statement of Disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You Have the Right to Receive an Accounting of Certain Disclosures We Have Made, if any, of Your Protected Health Information. To request this list or accounting of disclosures, you must submit your request in writing. Your request must state a period, which may not be longer than six years and may not include dates prior to April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred. The accounting must be provided to you no later than 60 days after the receipt of your request, unless we utilize the 30-day extension period.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this Notice of our Legal Duties and Privacy Practices with respect to Protected Health Information. If you do have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

MEDICAL INFORMATION RELEASE

Do we have your permission to:

- Leave a message on your answering machine at home? yes no
- Leave a message on your cellular phone? yes no # _____
- Leave a message at your place of employment? yes no
- Discuss your medical condition with members of
your family or anyone else? yes** no

**if yes, please list the name(s) of the people and their relationship to you. Please list your spouse and/or anyone who may call our office for you. If you do not list anyone, our doctors and office staff CANNOT discuss your medical information with anyone but you.

I, _____, give permission to be above doctors and/or staff to release information (verbal or written) about me, my medical condition and/or treatment to the following person(s).

NAME OF PERSON (please print)

RELATIONSHIP TO PATIENT

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

Office Use Only:

Our practice will make a good faith effort to obtain a written Acknowledgement of Receipt of the Notice provided to the individual. If written acknowledgment is not obtained, our practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

Refused to Sign: _____

Physically Unable to Sign: _____

Other _____

Employee Signature: _____

Date: _____

PROVIDER–PATIENT VOLUNTARY ARBITRATION AGREEMENT

Agreement to Arbitrate. The parties to this Provider–Patient Voluntary Arbitration Agreement (“Arbitration Agreement”) are Thomas Wright MD and Laser Lipo and Vein Center/Lakeview Medical (“Provider”), and the Patient named below. It is understood that any dispute as to medical malpractice—that is as to whether any medical services rendered or that were failed to be rendered by the Provider or by any of Provider’s agents, employees, associates, to the Patient were unnecessary or unauthorized, were improperly, negligently or incompletely rendered, or the failure to render such services was improper or otherwise negligent—will be determined by submission to arbitration binding upon the parties and not by a lawsuit or other resort to court or the judicial process except as state law provides for judicial review of arbitration proceedings. The parties recognize that, in Missouri, there is a right to appeal an arbitration award; however, unless there is evidence of fraud on the part of the arbitrator(s) or a serious procedural defect, an arbitration award pursuant to this Arbitration Agreement would not be overturned and would be a final award. The parties to this Arbitration Agreement, by entering into it, are waiving their constitutional right to have any such dispute decided in a court of law before a jury or before a judge and instead are accepting the use of arbitration as the appropriate and exclusive forum to resolve any dispute or controversy between them. **II. All Claims Must be Arbitrated.** It is the mutual agreement and intention of the parties that this Arbitration Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the Provider, including any spouse or heirs of the Patient, or any others making a claim on the Patient’s behalf, and any children. The term “Patient” herein shall include that individual receiving medical treatment or advice and, where applicable, shall include both the woman patient and the woman’s expected child or children. The term “Provider” herein shall include all of Provider’s agents and employees. The parties mutually agree that they shall submit to binding arbitration all disputes (except actions by the Provider to collect a fee) against each other and their respective agents, partners, associates, employees, representatives, governing bodies, affiliates, insurers, attorneys, for all disputes arising out of or in any way related to or connected with the care and treatment of the Patient provided by the Provider, including but not limited to any disputes concerning alleged personal injury to the Patient caused by improper or inadequate care; allegations of medical malpractice; claims of loss of consortium, wrongful death and emotional distress; any disputes concerning whether any statutory provisions relating to the Patient’s rights under Missouri law were violated; any claim for punitive damages; and any other dispute under Missouri or federal law based on contract, tort or statute, all of which shall be determined by submission to binding arbitration and not by a lawsuit or resort to judicial process except as state law provides for judicial review of arbitration proceedings. The filing of any action in any court by the Provider to collect any fee from the Patient shall not waive the right to compel arbitration of any other claim as described above. Following the assertion in court of any claim against the Provider, however, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration. **III. Procedures and Applicable Law.** A demand for arbitration under this Arbitration Agreement must be communicated in writing to all parties. Each party shall select an arbitrator (“Party Arbitrator”) within thirty (30) days of such demand, and a third arbitrator (“Neutral Arbitrator”) shall be selected by the appointed Party Arbitrators within sixty (60) days thereafter. In the event the two Party Arbitrators fail to select the Neutral Arbitrator within the sixty (60) day period, a third arbitrator will be appointed from a panel of five arbitrators supplied by Pinnacle Arbitration and Mediation Services, Saint Louis, Missouri 63108. Within thirty (30) days of the panel of five arbitrators being supplied, the parties will each strike two arbitrators on the panel according to the following procedure and the remaining arbitrator will be the Neutral Arbitrator. Either party shall have the right to request the state circuit court located in the county where the Patient resides or where the Provider’s principal place of business is located to appoint a neutral arbitrator in the event that the method provided herein fails, and the court’s selection shall be final and binding on the parties. Each party to the arbitration shall pay one hundred percent (100%) of the expenses and fees of its own Party Arbitrator and fifty percent (50%) of the expenses and fees of the Neutral Arbitrator as well as other expenses and fees of the arbitration, not including its own counsel fees or witness fees or other expenses incurred by a party for such party’s own benefit. The arbitrators shall apply the laws of the State of Missouri, including the applicable statute of limitations and the limitation on damages applicable to medical malpractice cases against health care providers, which is found in Chapter 538 of the Revised Statutes of Missouri. The arbitration hearing will be held before a panel of three (3) arbitrators unless the parties agree otherwise. A decision by the majority of arbitrators hearing the case shall be the final decision of the arbitrators in the arbitration. Any party to the arbitration as set forth in this Arbitration Agreement may be represented by an attorney of his or her choice at his or her own expense. The arbitrators will hear the facts and reach a decision whether or not the parties are represented by an attorney. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action and upon such intervention or joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding or else waived. A claim shall be waived and forever barred if: (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable state

statute of limitations; (2) the Patient fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence; or (3) the Patient fails to raise all potential claims from the same incident, transaction or related circumstances to the arbitration proceeding. **Acknowledgements:** Upon signing this Arbitration Agreement submitting to binding arbitration all disputes or controversies arising out of the Provider's services provided to Patient, the Patient hereby acknowledges the following: The Patient, and/or his or her legal representative, understands that he or she has the right to consult with an attorney of his or her choice before signing this Arbitration Agreement. The Patient, understands, agrees to, and has received a copy of this Arbitration Agreement, has had an opportunity to ask any questions about this Arbitration Agreement and has entered into this Arbitration Agreement willingly. Each party agrees to waive the right to a trial, before a judge or jury, for all disputes (except actions by the Provider to collect a fee) as stated above, subject to the provisions of binding arbitration under this Arbitration Agreement. This Arbitration Agreement may be revoked by Patient upon written notice delivered to the Provider within thirty (30) days of the Patient's signature date, and if not revoked within that time frame, it will govern all claims regarding medical services involving Patient and Provider. The Patient, and/or his or her legal representative, acknowledges that he or she has read carefully each provision of this Arbitration Agreement and the Introduction to the Provider-Patient Voluntary Arbitration Agreement and has a received a copy of each. **Miscellaneous:** The original Arbitration Agreement is to be filed in Patient's medical records. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. Prior to signing this document, Patient may confer with Provider in order to request any change or modification to the provisions of this document. If Patient intends this Arbitration Agreement to cover services rendered before the date it is signed (for example, emergency treatment), Patient should initial below. Effective as of the date of first medical services. _____ (Patient's initials). **The undersigned acknowledge that each of them has read this arbitration agreement and that by signing this arbitration agreement, each has waived his or her right to a trial before a judge or a jury, and that each of them voluntarily consents to all the terms of this agreement. This contract contains a binding arbitration provision which may be enforced by the parties.**

By: LaserLipoAndVein/Lakeview Medical Group: _____ Date _____

Patient (SIGNATURE) _____ Date _____

Patient (PRINT NAME) _____