COVID-19 PATIENT SCREENING QUESTIONNAIRE

Patient Name: ______________________________________ **DOB:** _________________

1. **Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms?**

Fever or feeling feverish	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Shortness of breath or difficulty breathing	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
New loss of taste or smell	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Head or muscle aches	☐ Yes	☐ No
Nausea, diarrhea, vomiting	☐ Yes	☐ No

2. **In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?**
   ☐ Yes ☐ No

3. **In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?**
   ☐ Yes ☐ No

4. **Have you been tested for COVID-19?**
   ☐ Yes What was the result? ________________________________
   Date you were tested ________________________________
   ☐ No

5. **In the past 14 days, have you been on a commercial flight or traveled outside of the United States?**
   ☐ Yes ☐ No

6. **Do you have the following:**

Heart Disease	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Autoimmune Disorder	☐ Yes	☐ No

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature:____ Date:_____________________________

Liberty Doctors

Patient Registration Form

PATIENT INFORMATION

Preferred Pharmacy	*Local pharmacy. This will be used to electronically send your prescriptions when possible.		In order to have access to your Medication History, Liberty Doctors needs your authorization. (PBM consent) Yes □ No □		
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
E-Mail		Date of Birth		Sex	M F
Marital Status	S M D W SEP	SSN		Race	
Preferred Language		Ethnicity			

RESPONSIBLE PARTY INFORMATION (if other than patient)

Relationship to Patient		*This area to be completed if responsible party is someone other than the patient (ie: minor child, legal guardian, etc…)			
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
Date of Birth		SSN		Sex	M F

PRIMARY INSURANCE INFORMATION

Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer	
Policy Holder DOB		Policy Holder SSN			

SECONDARY INSURANCE INFORMATION

Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer	
Policy Holder DOB		Policy Holder SSN			

Emergency Contact Name		Phone #	
Patient/Legal Guardian Signature		Date	
Liberty Doctors Employee Witness Signature		Date	

Consent for Treatment, Assignment of Benefits, Release & Financial Policy

Thank you for choosing Liberty Doctors (**LD**) to meet your medical needs. We are dedicated to providing the best treatment available. **Carefully read and initial each section and sign and date the bottom.**

Patient Consent for Treatment

I voluntarily consent to any and all heath care treatment and diagnostic procedures provided by LD and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further stat that I understand that no guarantee has been or can be made as to the results of treatments or examinations at LD.

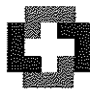
Initials_______________

Assignment of Benefits & Release of Information

I hereby authorize treatment of myself or the minor described above. I hereby authorize LD to release my medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company be assigned to LD. I understand that I am ultimately responsible for the balance of my account.

I authorize the release of all medical information necessary for LD to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer.

I authorize LD to obtain all of my medication/prescription history when using an electronic system to prescribe medications. I acknowledge that I retain the right to review LD Notice of Privacy Practices in the office upon request.
88
Initials_______________



Financial Policy

Missed Appointments: A Missed Appointment fee may be charged if you do not show up for a scheduled appointment, or cancel with less than 24 hour notice. This fee must be paid before a new appointment is scheduled. You may be discharged from Liberty Doctors if you have more than 3 Missed Appointments.
Initials________________

Account Balances: Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to services being rendered. If you are unable to pay your balance in full, we will reschedule your appointment until payment arrangements have been established. If you have fail to make appropriate payment arrangements after 2 billing statements, your account may be turned over to an outside collection agency. If you have established a payment plan and fail to meet agreed upon terms, your account may be turned over to a collection agency. Accounts assigned to Collections may be charged a $50 fee. Accounts turned over to an outside collection agency may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.
Initials________________

Returned Checks: There is a $35.00 fee for returned checks. This fee plus your balance is due when you are notified of the returned check.
Initials________________

Insurance: LD participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. A **Valid Driver's License** and **Insurance Cards must be presented** at each visit. If you do not have your up to date insurance card, we will be happy to reschedule your appointment or classify your appointment as self-pay.
Initials________________

Self-Pay patients and patients who have not met their deductible are required to pay for services in full prior to leaving. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. Please be aware there is a time limit on how long we have to file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. Please be aware that some and perhaps all of the services you receive may be non-covered by Medicare or other Insurers. You are responsible for any and all portions of the bill not covered by your insurance plan. You must pay for these services in full at the time of visit. **Co-pays must be paid Prior to services being rendered.** Your Insurance Company may deny the claim if co-pays are not collected and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we will have to reschedule your appointment. **Deductibles and co-insurance fees must be paid at check-out**. Patients who are unable to pay for the services as required by their insurance will be required to speak with an account representative to set up a payment plan.
Initials________________

Signature of Patient or Responsible Party: ____________________________ **Date:** ______________

Signature of LD Employee Witness: ____ **Date:** ______________

Liberty Doctors, LLC

Communication Policy

- Patients must notify Liberty Doctors, LLC of any changes or updates to their demographic and/or TPP information.

- Patients will be informed by Liberty Doctors, LLC of their payment responsibility at the time of their visit. If a patient has an outstanding balance after a TPP adjudication, [the Office] will contact the patient with an invoice statement outlining the patient's payment responsibility. Liberty Doctors, LLC will also contact the Patient by phone call if a balance remains outstanding after 3 statements.

- Any charges denied by the TPP due to inaccurate and/or out-of-date information will automatically be dropped to patient's responsibility. The patient will be responsible to pay the balance or provide accurate/up-to-date information so that Liberty Doctors, LLC can file to the TPP.

- Patient accounts with outstanding balances will receive a statement every 30 days until the 2nd statement or payment in full. If the balance has not be resolved by the third statement, Liberty Doctors, LLC will contact the patient with a phone call and send notice on the third statement informing the patient that the balance will be sent to collections if not resolved in the next 14 days.

Liberty Doctors, LLC

Designated Party Release

You may give Liberty Doctors, LLC written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information, such as results for labs, x-ray, prescription refills, and appointment reminders, on your home answering machine, voicemail at work, cell phone, email or with another party you designate.

Date:________________________ Account/Chart#____________________________

Patient Name: ____
Date of Birth:__________________

I authorize **Liberty Doctors, LLC** to disclose my Protected Health Information (PHI) to the following individuals:

Name: ____
Phone:______________________

Name: ____
Phone:______________________

Name: ____
Phone:______________________

I authorize **Liberty Doctors, LLC** to communicate my Protected Health Information (PHI) to me via the following methods:

_____Detailed message on my home phone answering machine
Phone:_______________

_____Detailed message on my voicemail at work
Phone:_______________

_____Detailed message on my cell phone voicemail
Phone:_______________

_____Email detailed Medical Information Email: __________________________________

Authorized Signature:____
Date:________________

LIBERTYDOCTORS

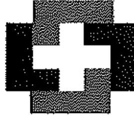
ASSURING HEALTHCARE FREEDOM

STOP – Cancellation Notice!

I understand that I may cancel this authorization at any time by signing the notice below. However, if I cancel this authorization, I also understand that the cancellation will not affect any actions taken by Liberty Doctors, LLC in accordance to this authorization prior to the receipt of written notice of cancellation.

Printed Patient Name:________________________________

Signature Authorizing Cancellation:
__________________________**Date:**________________



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (please print)

Patient's Name: ______________________

Date of Birth: ________________________

Phone Number: ________________________

PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF PATIENT CARE

FROM:

NAME OF PRACTICE: ____________________________________

PRACTICE FAX: ____

TO:

LIBERTY DOCTORS, LLC d/b/a

PHONE NUMBER:

FAX NUMBER:

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory / x-ray results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF ALL MEDICAL RECORDS

Patient Signature: ______________________________ Date ______________

Office Manager: ________________________________ Date: ______________

WE WELCOME YOU TO LIBERTY DOCTORS!

We look forward to many years of medical service to you and your family. Our offices are conveniently located and open Monday thru Friday. If you have an emergency after hours or on the weekend, the answering service will contact the physician on your behalf.

PRESCRIPTIONS

Please allow 24-48 hours for prescription refills. If your prescription needs to be picked up at the office during operating hours be sure to provide identification to receive your prescription.

REFERRALS

On certain occasions, Liberty Doctors, LLC will refer a patient to a specialist or a medical facility for a procedure. Liberty doctors, LLC will make every effort possible to obtain prior approval through your insurance company. It will be the patient's ultimate responsibility to make sure their insurance company has approved this visit or procedure, prior to the visit or procedure being performed.

PAYMENT OF SERVICES

Liberty Doctors, LLC accepts all major insurance companies. As a courtesy to our patients we will file with your insurance company. Please provide a valid insurance card and appropriate information so your claims may be files in a timely manner. Patients are responsible for copays and deductible at the time of service. We accept all major credit cards, personal checks, and cash. Uninsured patients are offered a 20% discount. Payment is due at the time services are rendered.

Chart #:________________

Liberty Doctors, LLC

Please fill out form completely. The following information will help us in providing you the best medical care and treatment possible. If you have questions, please ask the front desk clerk or the nurse. Thank you and we look forward to seeing you today!

Patient's Name:____ Today's Date:_______________

Date of Birth:___/___/____

Who is your Primary Care Doctor?____

Name Phone Number

List ALL medications you are currently taking (including over the counter and vitamins/supplements).

Medications	MGS	How Often

List any ALLERGIES

Medication Allergy	Reaction

LATEX ALLERGY Y N ADHESIVE ALLERGY Y N

Medical History of Patient

Heart Disease	Y	N	Asthma	Y	N
High Blood Pressure	Y	N	Depression	Y	N
High Cholesterol	Y	N	Stroke	Y	N
Diabetes	Y	N	Hypothyroidism	Y	N
Seizure	Y	N	Cancer	Y	N
Mental	Y	N	Type of Cancer:____________________		

Other:______________________________

Social History

Do you smoke?	Y	N	How many cigarettes per day?__________
Any other forms of tobacco?	Y	N	List:______________________________
Do you drink alcohol?	Y	N	How often?_________________________
Do you use any illicit drugs?	Y	N	Marijuana ___ Cocaine___ Other___

Marital Status

Married Single (never married) Divorced Separated Widowed

Chart #:________________

What is your occupation?____

What is your highest level of educations?____

Family History

Does anyone in your family (living or deceased) have the following: (please check all that apply)

☐Mother ☐ Father ☐ Sibling ☐ Grandparents

High Blood Pressure:____

High Cholesterol:____

Cancer:____

Stroke:____

Heart Disease:____

Diabetes:____

Depression:____

Mental (please be specific):____

Hypothyroidism:____

Other:____

Surgical History

Please select /list all surgeries:			Surgery Dates:
Appendix	Y	N	________________
Tonsils/Adenoids	Y	N	________________
Hysterectomy	Y	N	________________
Gallbladder	Y	N	________________
C-Sections	Y	N	________________
Heart	Y	N	________________ (type of surgery)________________

Other:____

Females Only

Are you pregnant? Y N

Last Menstrual Cycle:________________________

Last Pap Smear:________________

Abnormal Pap: Y N

How many times have you been pregnant?________

How many live births:________________________