

LISA A. DAVIS M.D., P.A.

PATIENT/CLIENT NAME: _____

SOCIAL SECURITY: _____

DATE OF BIRTH: _____

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, as the patient (or the patient's duly authorized representative) and do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments and transfers to other facilities considered necessary or advisable in the judgment of the attending physicians, his/her assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations performed in this facility. I authorize Lisa A Davis, M.D.,P.A. or members of its attending staff to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, specimens and I certify by my signature that I understand and accept its contents, expect as noted.

FINANCIAL RESPONSIBILITY STATEMENT

It is the policy of Lisa A Davis, M.D. P.A. to bill your insurance carrier as a courtesy to you, even though you may be considered responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days, the applicable balance will then be due in full from you. Unless your insurance company has a contract with Dr Davis to pay based on a specific negotiated fee schedule, you may be held responsible for any difference remaining between the insurance payment and the total charges. We also require that arrangements for payments of your estimated share be made today. If your insurance carrier in excess of the balance of your account subsequently makes any payment, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Lisa A Davis MD,PA.

However, if you are an HMO enrollee, the above statements only apply to your applicable co-pay and/or any other non-covered charge that you have agreed to be responsible for in advance of treatment. You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Lisa A Davis MD PA, you will be responsible for all costs of collecting monies owed including court costs, collecting agency fees and attorney fees. You also understand that you are responsible for keeping Dr Davis advised of any address changes. If any correspondence is returned, you understand that the account will be considered in default and will be turned over for collection immediately. The above information has been read and your signature on the front side of this form signifies that you understand your responsibilities for the payment of your account.

RELEASE OF INFORMATION

I hereby authorize Dr Davis MD to release information to my insurer(s), their agent(s), including employer, if work related injury), about my injury or disability, medical condition, evaluation, treatment, work history or any and all medical information as may be necessary for payment of my hospital and medical claims, except as otherwise provided by applicable State or Federal laws. This release also allows information to be released for utilization review and financial audits or for the purpose of evaluation, treatment, and/or rehabilitation. This may include all reports and others contained in the medical record pertaining to the medical condition or injury for which I have sought treatment. In addition, this release authorizes Dr Davis, MD to release my records to any referred physicians for purpose of continued medical care. This will include all pertinent clinical notes, diagnostic test, and personal information. Also, any medical information returned from referral physicians used for Case Management purposes can be released to the above listed entities. I understand that this authorization may be revoked by me at anytime and that it is valid for a period which is consistent with the Medical Records Policy of Lisa A Davis MD, PA and its personnel are hereby released from all legal responsibility for such release of information as described above. A photocopy of this document shall be considered to be as valid as the original.

BENEFIT ASSIGNMENT

I hereby assign all medical and/or surgical benefits to include major benefits to which I am entitled, including Medicare, private insurance and any other health plans to Lisa A Davis MD. A photocopy of this assignment is to be considered as valid as the original. Your signature below signifies that you read and acknowledge the policies explained on both sides of this form regarding 1) Release of information, 2) Benefit assignment, 3) Consent for treatment and 4) the financial responsibility statement.

Patient or Responsible Party

Date

Lisa A Davis MD PA Representative

Date

NO SHOW POLICY

Thank you for the confidence you have placed in my office for your medical needs. The providers in this office will prescribe an individual treatment plan of care for your condition. This treatment plan will require commitments from both you and the providers.

Once this treatment plan is agreed to, the provider will need to monitor your progress and may require you to attend visits at the clinic. In order to insure the availability of appointments for those who need services, the clinic has established a "No Show" policy. A "No Show" appointment occurs when you do not show up for a scheduled appointment.

Monitoring your condition is very important to the successful outcome of your care. It is for this reason if you fail to attend your appointment with the office you may be charged a \$25.00 fee for appointments that are not kept. If the problem continues, you may be discharged from the practice.

We ask that if you are unable to make your scheduled appointment, you call the office at least 24 hours in advance. The staff will make every effort to reschedule you at a time that is convenient for you and the provider, based on the urgency of the appointment.

I have read and understand the "No Show" policy as outlined above.

Name of Patient: _____ DOB: _____
Print

Signature of Patient/Responsible Party: _____

Date Signed: _____

May 12, 2003
Effective of the Notice of Privacy Practice



Dr. Lisa A. Davis, M.D., F.A.C.P.
520 Camden Street, San Antonio, Tx 78215
Ph: 210-223-3246 Fax: 210-223-1816

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

Lisa A. Davis, M. D., P. A uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, to communicate with other health care professionals involved in your care and to evaluate the quality of care that you receive. Your health information is contained in an electronic medical record that is the physical property of Lisa A. Davis, M. D. 1 P.A.

How Lisa A. Davis, M. D., P.A. May Use or Disclose Your Health Information

For Treatment. We may use your health Information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them during your treatment and note how you respond to the actions. We may use your health information when referring you to other health care professionals and facilities.

For Payment. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The Information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used during treatment. We may use your information to contact you about account balances.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to: Evaluate the performance of our staff Assess the quality of care and outcomes in your cases and similar cases; Learn how to improve our facilities and services; and determine how to continually improve the quality and effectiveness of the health care we provide.

May 12, 2003

Effective of the Notice of Privacy Practice

Required by law We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority.
- To report information related to victims of abuse, neglect, or domestic violence.
- To assist law enforcement officials in their law enforcement duties.

Appointment Reminders and Treatment Calls. We may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family. Our health professionals and staff, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Business Associates. Lisa A. Davis, M. D., P.A. may disclose your health information to a business associate so that they can perform their job functions. An example includes arrangements with business associates to provide collection services. In order to protect your health formation, however, Lisa A. Davis, M. D., P.A. requires the business associate to safeguard your information.

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Acknowledgment Form

Dear Patient,

Attached is a copy of Lisa A. Davis, M. D., P. A. 's Notice of Privacy Practices. This Notice of Privacy Practices describes your privacy rights and how Dr. Lisa Davis will use and to whom we will disclose your protected health information. The Notice of Privacy Practices is yours to keep.

In addition to the attached Notice of Privacy Practices, this page serves as a form titled Acknowledgement Form. Please sign this Acknowledgement Form below and return to the Medical Receptionist before leaving our practice. This Acknowledgement Form will be kept at our office, indicating that you have received our Notice of Privacy Practices.

If you have any questions, please don't hesitate to call our office.

I understand that as part of my health care, Lisa A. Davis, M. D., P.A. originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health care professionals who contribute to my care A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were provided and a tool for routine healthcare operations such as assessing quality of care and reviewing the competence of health care professionals.

Lisa A. Davis M. D., P.A. was unable to obtain acknowledgment /consent because:

- Emergency
- Patient Sedated
- Patient Nonresponsive
- Patient Confused Disoriented
- Patient Refused Reason _____

May 12, 2003
Effective of the Notice of Privacy Practice

HIPPA RELEASE AUTHORIZED DISCLOSURE

I _____ hereby authorize Lisa Davis, M.D., PA to disclose my protected health information to the following:

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Patient signature/Legal Representative

Date

Date of Birth

Signature of Office Staff

Date

Name _____

DOB _____

Lisa Davis, MD, F.A.C.P.
520 Camden
San Antonio, Texas 78215
210-223-3246

List names of Specialists and what they are treating you for

Preventative Care			
List Vaccines	Dates		
FLU			
Pneunovax 23			
Prevnar 13			
Prevnar 20			
Tetanus			
Shingrix			
Zostavax			
RSV			
Chicken Pox			
Hepatitis B			
Gardasil			
Covid-19	#1		
	#2		
Procedures			
Colonoscopy			
Men: Date of last PSA			
HIV Screening			
Women: Date of last Pap			
Mammogram			
Eye Exam			

HEP C Screening			
DEXA			

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Initial Health History Form

Name _____

DOB _____

Date _____

What is the reason for your initial appointment?

Who referred you? _____

Personal Medical History:			
Please check any of the following that you have been diagnosed with:			
Diabetes		Circulation Problems	Psoriasis
High Blood Pressure		Kidney Disease	Eczema
High Cholesterol		Kidney Stones	Rosacea
Heart Attack		Recurrent Urine Infections	Other Skin Disorders
Heart Murmur		Enlarged Prostate	Sleep Apnea
Atrial Fibrillation		Erectile Dysfunction	Asthma
Aneurysm		Prostate Cancer	COPD / Emphysema
Rheumatic Fever		Hepatitis A B C	Bronchitis
Congestive Heart Failure PAD		Cirrhosis	Pneumonia
Thyroid Disease		Liver Disease	Anemia
Adrenal Gland Disorder		Parathyroid Adenoma	Leukemia
Depression		Bipolar	Blood Clotting Disorder
Anxiety / Panic Attacks		Other Mental Illness	
Suicide Attempt		Rheumatoid Arthritis	HIV
Peptic Ulcer		Lupus	MRSA
Reflux		Gout	Syphilis
Hiatal Hernia		Fibromyalgia	Gonorrhea

Name _____

DOB _____

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Surgeries					
Heart bypass		Appendix		Back	
Leg bypass		Gallbladder		Hip	
Valve replacement		Tonsils		Knee	
Pacemaker		Prostate		Thyroid	
Heart stent		Tubal ligation		Hernia	
Carotid		C-section		Abscess	
Heart cath		Hysterectomy		Cosmetic surgery	
List any other surgeries					
List all hospitalizations and ER visits and approximate date:					
Allergies to medications and what was the reaction:					
1.		7.			
2.		8.			
3.		9.			
4.		10.			
5.		11.			
6.		12.			

Colon Polyps		Chronic Pain		VD	
Ulcerative Colitis		Herniated Disc		Neuropathy	
Crohn's		Neck Problems		Nerve Damage	
Irritable Bowel		Migraine Headaches		Multiple Sclerosis	
Hemorrhoids		Tension Headaches		Stroke	
Osteoporosis		Seizures		Dementia	
Osteoarthritis		Acne		Alzheimer's	
Parkinson's		Glaucoma		Retinopathy	

Any other major or chronic medical problems please list:

Ever have blood transfusions? YES _____ NO _____

BRING ALL BOTTLES OF CURRENT MEDICATIONS

If you do not have, please list.

1. _____

2. _____

3. _____

4. _____

5. _____

Name _____

DOB _____

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Family Medical History

Please check if any of your blood relatives have:

Diabetes	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Cancer of:	<input type="checkbox"/>
Premature Heart Disease	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Breast	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	Colon	<input type="checkbox"/>
Aneurysms	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	Ovaries	<input type="checkbox"/>
Kidney Failure	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>		<input type="checkbox"/>

Health History of:

Mother	Living	<input type="checkbox"/>	Has history of: _____ died age _____ From _____
	Well	<input type="checkbox"/>	
	Age	<input type="checkbox"/>	
Father	Living	<input type="checkbox"/>	Has history of: _____ died age _____ From _____
	Well	<input type="checkbox"/>	
	Age	<input type="checkbox"/>	

Health status or cause of death of brothers and sisters:

Social History

Occupation?
If retired, from what?
If disable. Disabled due to what?
Who do you live with?

Name _____

DOB _____

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Please check all that apply:					
Single	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>
Married	<input type="checkbox"/>	Ex -Smoker	<input type="checkbox"/>	Tattoos	<input type="checkbox"/>
Widowed	<input type="checkbox"/>	Non-Smoker	<input type="checkbox"/>	Piercing	<input type="checkbox"/>
Divorced	<input type="checkbox"/>	History of drug abuse	<input type="checkbox"/>	Multiple Sex Partners	<input type="checkbox"/>
Significant Other	<input type="checkbox"/>	IV Drug Use	<input type="checkbox"/>		<input type="checkbox"/>
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Education					
Did not finish high school	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
High School	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Some College	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
College Degree in					
Masters	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
PhD	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Do you have a DNR or Living Will? Yes					

May we contact you by email regarding results or appointments? Yes ___ no ___
If yes, initial here _____

Email address _____

Name _____

DOP _____

The CAGE Questionnaire

1. Have you ever felt you should cut down on your drinking?

Yes

No

2. Have people annoyed you by criticizing your drinking?

Yes

No

3. Have you ever felt bad or guilty about your drinking?

Yes

No

4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

Yes

No

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name _____

DOB _____

GAD-7 Anxiety

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer"</i>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: ___ + ___ + ___ + ___

= Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult











Extremely difficult

Name: _____

Phone number: _____

Preferred Language: _____

Best time to call: _____

		Yes / No
	In the last 12 months*, did you ever eat less than you felt you should because there wasn't enough money for food?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are you worried that in the next 2 months, you may not have stable housing?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do problems getting child care make it difficult for you to work or study? <i>(leave blank if you do not have children)</i>	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, have you needed to see a doctor, but could not because of cost?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do you ever need help reading hospital materials?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do you often feel that you lack companionship?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	<input type="checkbox"/> Y <input type="checkbox"/> N
	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	<input type="checkbox"/> Y <input type="checkbox"/> N