

PATIENT REGISTRATION FORM

NAME: _____ DATE OF BIRTH: _____
FIRST MIDDLE LAST MM/DD/YY

PREFER NAME: _____ MARITAL STATUS: S M D W

ADDRESS: _____
STREET # STREET NAME APT #
CITY STATE ZIP

PHONE #: _____ SOCIAL SECURITY #: _____ SEX: M F
EMAIL: _____

EMERGENCY CONTACT: _____
NAME PHONE #

EMPLOYER: _____
NAME PHONE #

STREET CITY STATE ZIP

GUARANTOR: _____ DATE OF BIRTH: _____
(POLICY HOLDER) FIRST MIDDLE LAST MM/DD/YY

GUARANTOR ADDRESS: _____
STREET CITY STATE ZIP

GUARANTOR PHONE #: _____ SOCIAL SECURITY #: _____

PATIENT RELATIONSHIP TO GUARANTOR: SELF SPOUSE CHILD

GUARANTOR EMPLOYER: _____

NAME AND # OF PHARMACY YOU PREFER TO USE: _____

ARE YOU A STUDENT: FULL PART TIME SCHOOL NAME: _____

WHO REFERRED YOU? _____
NAME PHONE #

Should my account fall into the arrears greater than 60 days, I authorize that unpaid balance to be charged to my major credit card, as listed below.

VISA: _____ MASTERCARD: _____ CARD #: _____
EXPIRATION DATE: _____ NAME AS IT APPEARS ON CARD: _____

SIGNATURE DATE
*PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.

DO WE HAVE YOUR PERMISSION TO:
LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME?: YES NO
LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT?: YES NO
DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD?: YES NO
IF YES, WITH WHOM: _____ RELATIONSHIP: _____

I agree that the above information is correct and that I have provided the receptionist with the correct insurance information:
Signature: _____ Date: _____

Dermatology Medical History

Patient: _____ Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? YES NO If YES, list: _____
Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reactions? YES NO

List any medications you are currently taking (Prescriptions, over-the-counter meds, Aspirin, vitamins, herbs):

- 1. _____ 3. _____ 5. _____
- 2. _____ 4. _____ 6. _____

Do you have now or have you ever had diseases or conditions of: (Please \checkmark YES or NO)

Lungs:		YES	NO	Other Systemic:		YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Amputation	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>		Kidney	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	
				Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
				Frequency/Burning	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular:	YES	NO		Stomach Absorptive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Nausea, vomiting, diarrhea			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Date: ___/___/___	Yeast Infection when taking			
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>		antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	
Inflammation of Vein	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>		Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Date: ___/___/___
				Convulsions, Epilepsy or			
				Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
				Fainting	<input type="checkbox"/>	<input type="checkbox"/>	

Do you have any condition requiring antibiotics before dental procedures? YES NO

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO If YES, who? _____ What kind? _____

Do you have a history of any specific skin diseases? YES NO

Do you have problems w/ healing or develop keloids (scars)? YES NO

Do you bleed easily? YES NO

Do you develop skin rashes in reaction to: Medications Food Environment Bandages Topical Neosporin

Other _____

Social History:

Do you drink alcohol? YES NO If YES, _____ drinks/day

Do you use IV drugs? YES NO If YES, what? _____ How often? _____

Do you use tobacco? YES NO If YES, how much? _____

Have you ever been exposed to HIV (AIDS)? YES NO

(Women) Are you pregnant? YES NO Due Date: ___/___/___

What is your occupation? _____ Hobbies? _____

Completed by: Patient

Signature of Patient

Date

Other _____

Reviewed by

Date

Dr. Lloyd J. Cleaver
700 West Jefferson
Kirksville, MO 63501
(660) 626-2191

Patient Name _____

Date _____

- | | | |
|--|-----|----|
| 1. Have you ever had TB (tuberculosis)? | Yes | No |
| 2. Have you been living with anyone in the past 2 years who have been diagnosed with TB? | Yes | No |
| 3. Have you had a persistent cough and fever for more than 2 weeks? | Yes | No |
| 4. Have you had a persistent cough and night sweats for more than 2 weeks? | Yes | No |
| 5. Have you had a persistent cough or loss of appetite for more than 2 weeks? | Yes | No |
| 6. Have you been coughing up or spitting up bloody saliva? | Yes | No |

Reviewed by _____
(Nurse or Dr. signature)

Date _____

LLOYD J. CLEAVER, D.O., L.L.C.
700 West Jefferson, Kirksville, MO 63501
660-626-2191

OFFICE FINANCIAL POLICY

We would like to share the following policies with you so that you understand your responsibilities regarding the charges for the services rendered to you by this office. (Please initial each paragraph as you read this policy.)

Copays

The patient is expected to present an insurance card at each visit. All copayments and past due balances are due and payable at the time of service. _____

Self-pay accounts

Self-pay accounts are patients who are covered by insurance plans that the clinic does not participate in, patients without an insurance card on file, or at the time of service, do not meet the deductible. It is expected that payment is required at time of service for all services including all surgeries. _____

Extended payment arrangements

The patient is expected to pay at least 50% of the total fee. The balance is to be paid over the next three months in equal monthly payments due by the first of every month. Patients who fail to make a monthly payment will be sent to a collection agency and may be terminated from the practice. _____

Cosmetic or non-covered procedures

* You will be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by insurance. In the event that we are not aware of a charge that is not covered by your plan, you will be billed for the balance after we obtain a denial from you insurance carrier. _____

Patient refunds

The following criteria must be met prior to issuing a patient refund: The patient has not been seen in the office for 90 days, there are no outstanding insurance claims on the patient's account, and there are no outstanding patient balances on the account. _____

Child custody cases

The parent with primary custody is usually the parent with whom the child lives and who usually brings the child to the clinic for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurance, or nonparticipating insurance. If the non-custodial parent carries the insurance on the child, the clinic will bill that insurance company. The clinic does not get involved with divorce specifics, e.g., one parent pays 80% and the other pays 20%. It is the parents' obligation to work out an agreement themselves or through the court system. _____

Referrals

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your clinic visit. If this authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. _____

This financial policy helps the clinic provide quality care to our valued patients, If you have any questions or need further clarification of any of the above policies, please feel free to contact us.

Patient or Guarantor's signature

Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Lloyd J. Cleaver may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Dr. Lloyd J. Cleaver's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Lloyd J. Cleaver reserves the right to revise this Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Lloyd J. Cleaver's Privacy Officer at 700 West Jefferson, Kirksville, MO 63501.

With my consent Dr. Lloyd J. Cleaver may call my home or other designated location and leave a message on a voice mail or in person in reference to any items that assist the practice in carrying out TPO. Such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr. Lloyd J. Cleaver may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

By signing this form, I am consenting to Dr. Lloyd J. Cleaver's use and disclosure of my Personal Health Information to carry out treatment, payment, and healthcare operations. I have also received and reviewed the Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made a disclosure in reliance upon my prior consent. If I don not sign this consent, Dr. Lloyd J. Cleaver may decline to provide Treatment to me.

I hereby acknowledge that I have been presented with a copy of Dr. Lloyd J. Cleaver's Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Parent or Legal Guardian

Patient Name: _____

Date of Birth: _____

Please list the name(s) of the person(s) with whom you give us permission to discuss your medical condition as well as their relationship to you. (i.e. friend, neighbor, child, etc.)

Check here if you do not wish for us to discuss your condition with anyone other than yourself.

May we leave a message on your answering machine? ____ Yes ____ No

May we call you at work? ____ Yes ____ No

Patient Signature: _____

Date: _____

*You may change any of this information at any time. Please check with a receptionist or nurse and they will supply a new form for you. Thank you.

Notice of Privacy Practices
Dr. Lloyd J. Cleaver, DO, LLC

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information.

1. **Communications.** You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operation. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Connie Jones Privacy Officer for Dr. Lloyd J. Cleaver, DO, LLC, 700 West Jefferson, Kirksville, MO 63501.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to Connie Jones Privacy Officer for Dr. Lloyd J. Cleaver, DO, LLC, 700 West Jefferson, Kirksville, MO 63501. You must provide us with a reason that supports your request for amendment.
5. Right to obtain a copy of this notice. You are entitled to receive a copy of this Notice Of Privacy Practices. You may ask us to give a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Connie Jones Privacy Officer for Dr. Lloyd J. Cleaver, DO, LLC, 700 West Jefferson, Kirksville, MO 63501. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Connie Jones Privacy Officer for Dr. Lloyd J. Cleaver, DO, LLC, 700 West Jefferson, Kirksville, MO 63501.