LIBERTY HOSPITAL

Primary Care & Specialty Clinics

Comprehensive Health History

PATIENT FULL LEGAL NAME_____

DATE OF BIRTH_____

Have you ever, or do you:

SMOKE ☐ yes ☐ no Packs per day_____ Age quit _____ Any smokers in the home? ☐ yes ☐ no

SMOKELESS TOBACCO ☐ yes ☐ no ☐ quit How much? _____ Year quit _____

DRINK ALCOHOL ☐ yes ☐ no What forms? _____ Quantity _____ Frequency _____

ILLICIT DRUGS ☐ yes ☐ no What forms? _____ Quantity _____ Frequency _____

CAFFEINE USAGE ☐ yes ☐ no Coffee _____ Tea _____ Soda _____ Daily Amount _____

ALLERGIES (medication & food)

☐ No known medication allergies ☐ No known food allergies

List all medication and food allergies, please identify reaction _____

Are you allergic to latex or latex based products? ☐ yes ☐ no Tape? ☐ yes ☐ no Iodine? ☐ yes ☐ no

MEDICATIONS See attached list ☐

Medication	Dose	How often do you take	Medication	Dose	How often do you take

FAMILY HISTORY

Are your parents living? Mother ☐ yes ☐ no Father ☐ yes ☐ no Cause of death? _____

Please list any health conditions/serious illnesses that your mother, father, sister(s) or brother(s) have or have been told they have had in the past (i.e. diabetes, heart condition, high blood pressure, stroke, high cholesterol, cancer, thyroid, etc.)

Father _____

Mother _____

Sister(s) _____

Brother(s) _____

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PATIENT FULL LEGAL NAME_____

DATE OF BIRTH_____

PATIENT PAST MEDICAL

- ☐ Allergies
- ☐ Anemia
- ☐ Angina *(chest pain)*
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Atrial fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood clots *location* _____
  *P.E./DVT*_____
  When: _____
- ☐ Blood clotting disorder
- ☐ Cancer *location* _____
- ☐ Cerebrovascular accident *(stroke)*
- ☐ CHF *(Congestive Heart Failure)*
- ☐ COPD *(Chronic Obstructive Pulmonary Disease)*
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD or chronic heartburn
- ☐ Hepatitis A___ B___ C___
- ☐ Hyperlipidemia *(high cholesterol)*
- ☐ Hypertension *(high blood pressure)*
- ☐ Immune system disorder
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Malignant Hyperthermia
- ☐ Migraine headaches
- ☐ MRSA
- ☐ Myocardial infarction *(heart attack)*
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal *(kidney)* disease
- ☐ Seizure disorder
- ☐ Thyroid *high___ low___ other_____*

Other _____

Have you ever had General Anesthesia? Any complications? ☐ Yes ☐ No

PATIENT PAST SURGICAL

- ☐ Angioplasty *(heart cath)* *year*____
- ☐ Angio *(heart cath)* w/stent *year*____
- ☐ Appendectomy *year*____
- ☐ Arthroscopy knee *year*____
- ☐ Back surgery *year*____
- ☐ CABG *(heart bypass)* *year*____
- ☐ Carpal tunnel release *year*____
- ☐ Cataract extraction *year*____
- ☐ Gallbladder surgery *year*____
- ☐ Colectomy *(colon resection)* *year*____
- ☐ Colostomy *year*____
- ☐ Gastric bypass *year*____
- ☐ Hernia repair *year*____
- ☐ Hip/Knee replacement *year*____
- ☐ Lasik *year*____
- ☐ Liver biopsy *year*____
- ☐ ORIF *(fracture repair)* *year*____
- ☐ Pacemaker *year*____
- ☐ Small bowel resection *year*____
- ☐ Thyroidectomy *year*____
- ☐ Tonsillectomy *year*____

Other _____

PATIENT PAST SURGICAL - Women only

- ☐ Augmentation mammoplasty *(implants)* *year*____
- ☐ Bilateral tubal ligation *year*____
- ☐ Breast Biopsy *year*____
- ☐ Cesarean Section *year*____
- ☐ D & C *year*____
- ☐ Hysterectomy *(abdominal)* *year*____
- ☐ Hysterectomy *(vaginal)* *year*____
- ☐ Mastectomy *year*____
- ☐ Myomectomy *(Fibroidectomy)* *year*____
- ☐ Reduction mammoplasty *year*____
- ☐ Oopherectomy *(ovary removal)* *year*____
- ☐ TAH/BSO *year*____

Other _____

LIBERTY HOSPITAL

Primary Care & Specialty Clinics

Permission to Disclose Information to Those Involved in My Care

This form does not authorize releasing copies of my medical records.

I hereby allow the primary care and specialty clinics of Liberty Hospital to disclose the following information:

Check all that apply.

- ☐ Appointment times and dates
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Tests that have been performed
- ☐ Test results
- ☐ Billing/payment information

Other health information (describe)_____

To the following people who are involved with my healthcare and/or payment information:

Check all that apply and list names and phone numbers.

- ☐ Spouse_____Phone_____
- ☐ Friend_____Phone_____
- ☐ Child(ren)_____Phone_____
- ☐ Other_____Phone_____

Can confidential messages (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail?

Check all that apply.

- ☐ No, DO NOT leave messages
- ☐ Yes, at home
- ☐ Yes, at cell
- ☐ Yes, at work

Home_____

Cell_____

Work_____

I understand that in certain situations the primary care and specialty clinics of Liberty Hospital could speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permission at any time.

X Patient Name (please print):_____Date of birth:_____

X Patient/Guardian Signature:_____Date:_____

If patient is a minor, please complete the following information:

Mother's name/contact number:_____

Father's name/contact number:_____

LIBERTY HOSPITAL

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GENERAL CONSENT *(clinics)*

New Liberty Hospital District is a hospital district and political subdivision of the State of Missouri created pursuant to Chapter 206 of the Revised Statutes of Missouri and includes its affiliated entities (referred to collectively as "Liberty Hospital").

Authorizations/Consents

Consent for treatment: I consent to and authorize Liberty Hospital, including its clinic entities and affiliates, to provide healthcare services including examinations, diagnostic and laboratory procedures, anesthesia, medical treatment, and monitoring that are deemed advisable or necessary in my diagnosis and treatment. I consent and understand that this includes routine Human Immunodeficiency Virus (HIV) testing for my personal treatment when deemed medically necessary unless I otherwise refuse or "opt out" of testing. (All OB patients will have an HIV test completed upon admission unless previously completed in the clinic setting for current pregnancy or unless otherwise refused.) I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk or injury or even death. I understand that telehealth/telemedicine may be utilized as a mode of delivering health care services to me, via communication technologies to facilitate diagnosis, provide consultation, and treatment, and I authorize its use. I acknowledge that no guarantees have been made as to the result of examination or treatment at Liberty Hospital and its clinics.

Professional care: I understand I am under the professional care of attending physicians who arrange for services. I understand that health care personnel in training whose presence is under the supervision of trained professionals may be involved in my care and treatment, and I agree they may be present during my patient care as a part of their education.

Clinical photography and video/audio technology: I authorize Liberty Hospital, its clinics and my physicians to take photographs or other images of me or parts of my body to be used in medical evaluations, education or research. I authorize the use of video and audio technology to monitor, assess and interact with me while under the care of Liberty Hospital and its clinics, which can involve the delivery of healthcare by a provider who is at a different location.

Occupational exposure: Should a healthcare worker be exposed to my blood, body fluids, or tissue during my care, I hereby give consent to test the source of the exposure for the presence of hepatitis B virus surface antigens, Hepatitis C antibody and HIV antibodies. My healthcare provider will convey the results to me.

Acknowledgement and authorization regarding release of medical information: I understand that under certain circumstances that Liberty Hospital and its clinics are either required or permitted to release medical information and records as mandated by federal and/or state laws. I authorize Liberty Hospital and its clinics to release all medical information as necessary which may include information relating to mental health care, communicable diseases, HIV or AIDS, treatment of alcohol or drug abuse in accordance with such federal and state laws. I also authorize Liberty Hospital and its clinics to release medical information needed for continuation of medical care and treatment, claims defense and billing purposes to physicians and/or entities that provide services to me.

Behavior expectation: I agree that it is my responsibility to treat other patients, visitors and staff with respect. I understand that disrespectful behaviors will not be tolerated and may lead to evaluation for my discharge.

Service Terms:

Assignment of insurance benefits: I assign all my interest and rights to all insurance benefits, otherwise payable to me from anypolicy of insurance covering my period of hospitalization or clinical treatment, issued in my name or on my behalf to Liberty Hospital and its clinics. I authorize payment by my insurance carrier directly to the hospital, clinic, physician and consulting physicians of the applicable policy benefits, including major medical benefits to which I am entitled.

Personal financial responsibility and cooperation: In return for services rendered by Liberty Hospital and its affiliates, I am personally responsible for all Liberty Hospital and its clinics fees not paid by any third party on my behalf. I understand I will be charged in accordance with the regular rates and terms of Liberty Hospital and its affiliates. I understand that my account may be eligible for a discount under the Liberty Hospital financial assistance policy in effect at the time of treatment. I understand that if I do not qualify for the hospital's financial assistance policy, I, or my Guarantor, is not relieved of the obligation to pay for services rendered. I have been informed and agree to cooperate with Liberty Hospital and its clinics in submitting my application for any governmentally subsidized program that may provide partial or total reimbursement for certain services. If such program funds are available, I hereby authorize that funds be paid directly to Liberty Hospital and its clinics on my behalf and for my account, provided that no other third parties have paid such amounts.

Statement applicable to Medicare/Medicaid patients: I certify that any information I provide in applying for payment under TitleXVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits be made only on my behalf to Liberty Hospital and its clinics or the hospital-based physician by the Medicare or Medicaid program. I have been informed that some services may not be covered by my health insurance benefit plan or, if applicable, by Medicare. Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

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Third Party Billing and Collection: I acknowledge that Liberty Hospital and its clinics may utilize the services of a third party for medical account billing and servicing. Should the account be referred to an attorney for collection, the undersigned agrees to be responsible for and pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate.

Methods of Contact: I agree, in order to service my account, or to collect any amounts I may owe, and/or for healthcare communications, that Liberty Hospital, its clinics or its Business Associates may contact me by telephone, at any telephone number associated with my account, which could result in charges. I also agree to be contacted by text messages or e-mails (using any e-mail address provided). Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

General Terms:

Personal Belongings: I am informed and agree that I am responsible for all of my personal belongings brought to Liberty Hospital and its affiliates. I have been informed that I should send all personal belongings home for safe keeping while under care, and that weapons and illegal substances are not allowed in the hospital or its clinics.

Tobacco Free Campus: I understand that Liberty Hospital and its clinics are tobacco free. I acknowledge that I cannot smoke or use tobacco products of any kind anywhere on the hospital campus, including the parking lot, garages, or grounds of the facility and in its clinic locations and grounds.

Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices that describes my right to privacy and how the hospital and its clinics may use and disclose my protected health information, and that I have the right to ask Liberty Hospital and its clinics to request certain restrictions as to how my information will be used or disclosed.

Patient Rights: I acknowledge that I have been offered and provided access to the Liberty Hospital and its clinics Patient Rights and Responsibilities.

Financial Assistance: *[For hospital patients only]* I acknowledge that I have been offered and provided access to the Financial Assistance for Liberty Hospital Patients Summary.

Patient signature: _____/_____/_____
Date **Time**

Patient's representative: _____/_____/_____
Date **Time**

Relationship to patient: ___Relative ___Friend ___Court-appointed

Proof of guardianship / DPOA available? ___Yes ___No

Witness: _____/_____/_____
Date Time

Witness: _____/_____/_____
Second witness signature needed for verbal consent Date Time

Patient unable/unwilling to sign: _____/_____/_____
Printed name of staff attesting Date Time