Lykos Medical

PATIENT REGISTRATION FORM

(Print clearly & press firmly in black ink)

Today's Date_____

Patient Name_____
Last First MI Nickname

Date of Birth _____SSN _____Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-Mail _____

Primary Phone ( )_____May we leave a message? (circle) YES / NO

Secondary Phone ( )_____May we leave a message? (circle) YES / NO ____

Work Phone ( )_____OK to call work? (circle) YES / NO

Patient's Employer_____

Primary reason for today's visit_____

_____

Primary Care Physician_____Referring Physician_____
Last First Last First

Is this work-related? (circle) YES NO Related to an auto accident? (circle) YES NO *If YES on EITHER, please complete Auto/WC Form*

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____Policy #/ID _____Group # _____

Name of Policy Holder _____SSN _____ Date of Birth _____Gender (circle) F M

Relationship to Patient_____ Employer _____Employer Phone ( )_____

Secondary Insurance _____Policy #/ID _____Group # _____

Name of Policy Holder _____SSN _____ Date of Birth _____Gender (circle) F M

Relationship to Patient_____ Employer _____Employer Phone ( )_____

If you are a Medicare beneficiary, please circle any of the following that apply to you:

(circle) Working-Aged ESRD Auto/Med/No Fault Liability Workers Comp Federal Black Lung Veterans Affairs Disability Other Liability

If you do not have insurance, have you applied for government assistance? (circle) YES NO If yes, provide social worker's information.

Social Worker's Name_____Phone ( )_____

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone( )_____ Secondary Phone( )_____

Custodial Parent's SSN_____ Date of Birth_____

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name _____ Relationship _____Phone( )_____
Last First

Name of person we may speak with other than yourself regarding your medical care?_____

Primary Phone( )_____Secondary Phone( )_____Relationship_____

PATIENT INFORMATION SHEET

Lykos Medical

NAME: _____ GENDER: _____ DOB: _____ DATE: _____
ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

Lykos Medical

Patient Policies

Thank you for choosing Lykos Medical as your Primary Care Provider. Our experience has shown us that managing expectations is critical to ensuring a successful relationship with one another. Below is a list of various clinic policies that will guide our interactions in the future.

1. Appointments:
    - Clinic Responsibilities:
        - With every reasonable effort, we will get your appointment scheduled within a reasonable time frame of your requested follow up. Sometimes this may mean that you will have to see a different provider if your requested appointment block is full for your PCP.
        - Once checked in, your PCP will be the one to take you back to the exam room and begin your exam. We will make every reasonable effort to keep your appointment as close to the time scheduled as possible or reschedule your appointment at no charge.

    - Patient responsibilities:
        - Please do your best to maintain your appointments and try to arrive 15 minutes before the scheduled appointment. This allows us to complete your insurance verification and prep for your appointment.
        - If you cannot make the appointment on time, please call and notify us and we will do our best to adjust our schedule to accommodate the change and minimize disruption for other patients.
        - If you are more than 15 minutes late and the office has not been notified, your appointment will be canceled.

2. Pain Medication:
    - Lykos Medical Primary Care, in general, will not prescribe long term narcotic pain medication. We will also be exceptionally prudent with prescribing any narcotics in general. The State of Colorado and the DEA are closely monitoring these prescriptions and we intend to only prescribe them in the most serious of cases (i.e. severe new orthopedic injuries, wide spread cancer, etc.)
    - If you require a long term prescription for a narcotic pain medication, we are happy to work with any pain management specialist of your choice.

3. Professional behavior:
    - Patients understand that this is a professional work environment. Mutual respect and decorum will be reciprocated. If a patient and/or their family member/ significant other becomes aggressive or threatening in any way, Lykos Medical reserves the right to refuse services at any time.

Printed Name:_____ SSN: _____

Signature:_____ Date: _____

Lykos Medical

FINANCIAL POLICY

(Print clearly & press firmly in black ink)

Today's Date_____

Patient Name_____
Last First MI

Date of Birth _____SSN _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated.

Current insurance cards must be presented to the office at each visit. Any changes to personal information must be given to the office immediately.

ASSIGNMENT: I request that payment of authorized insurance, Medicare, and Medicaid benefits be made payable to Lykos Medical LLC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

_____ ***(Initial) I have read and agree to the above statement.***

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

_____ ***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Lykos Medical LLC to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____ ***(Initial) I have read and agree to the above statement.***

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

_____ ***(Initial) I have read and agree to the above statement.***

SELF-PAY: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

_____ ***(Initial) I have read and agree to the above statement.***

WORKERS' COMPENSATION: I will provide approval/authorization by the Workers' Compensation carrier at the initial visit. If the claim is deferred, the private medical insurance will be billed. I understand if the claim is denied, I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney and/or the Workers' Compensation carrier will be provided to this office.

_____ ***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS/NO SHOW CHARGE: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification. . I understand and agree to pay a $50.00 charge for appointments that I do not honor or do not call to cancel within 24 hours prior to the scheduled appointment.

_____ ***(Initial) I have read and agree to the above statement.***

PRIVACY POLICY: I have been made aware of the privacy policy of Lykos Medical LLC and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

PRINT NAME _____

SIGNATURE _____ DATE _____