

# LIBERTY CARDIOTHORACIC SURGEONS

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: \_\_\_\_\_

**Martial Status:** Married Single Divorced Widowed  
Spouse's Name: \_\_\_\_\_ Employer \_\_\_\_\_ Work #: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Primary Physician: (To send reports) \_\_\_\_\_

**Patient's Employer:** \_\_\_\_\_ Occupation: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Job Title: \_\_\_\_\_  
Date of Retirement (if applicable): \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Disability (if applicable): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Person to notify in case of emergency:** (Please list a person NOT living in your home)  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
#1 - Phone #: \_\_\_\_\_ #2 - Phone #: \_\_\_\_\_

**PRIMARY Insurance Company:** \_\_\_\_\_  
Insured's Relationship to Patient: Self Spouse Dependent Child Other  
Insured's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ S.S.#: \_\_\_\_\_

**SECONDARY Insurance Company:** \_\_\_\_\_  
Insured's Relationship to Patient: Self Spouse Dependent Child Other  
Insured's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ S.S.#: \_\_\_\_\_

**I authorize Liberty Cardiothoracic Surgeons to furnish my insurance carriers and other providers involved in my care the necessary medical information concerning my illness or injury. I also authorize payment directly to Liberty Cardiothoracic Surgeons for medical benefits. I understand that I am financially responsible for all charges whether or not covered by insurance.**

SIGNED: \_\_\_\_\_ **DATE & TIME:** \_\_\_\_\_  
(PATIENT OR AUTHORIZED PERSON'S SIGNATURE)

### LIFETIME CONSENT

**I request that payment of authorized Medicare benefits be made either to me or on my behalf to Liberty Cardiothoracic Surgeons for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.**

NAME OF BENEFICIARY (PATIENT): \_\_\_\_\_ DATE & TIME: \_\_\_\_\_

# LIBERTY CARDIOTHORACIC SURGEONS

## AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION PERMISSION TO DISCUSS YOUR MEDICAL CARE AND/OR FINANCES

### I. Persons to Whom your Medical Information May Be Disclosed

Except for other physicians in connection with your ongoing care, insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies (allowed by federal law), and workers compensation agencies, we cannot release ANY of your medical information to any person or organization (including spouse, family member, etc.) unless you list their name below.

You agree the information described above may be disclosed to the following persons or organizations:

\_\_\_\_\_  
Name of person / organization

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name of person / organization

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name of person / organization

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name of person / organization

\_\_\_\_\_  
Relationship

### II. The Purpose and type of Information Disclosed (cross out if permission not given, otherwise we will understand that you are approving this information to be shared):

1. General information: current medical condition, prognosis, medications, etc.
2. Laboratory and/or Radiology tests results.
3. Financial details of your billing activity and/or charges.

### III. Expiration Date or Authorization

Your permission to disclose this information is effective one year from the date listed by you, on this form, unless revoked or terminated in writing by you or your personal representative.

### IV. You have the Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Liberty Cardiothoracic Surgeons.

I understand that this authorization will remain in effect until I give written notice to Liberty Cardiothoracic Surgeons to remove any of the persons listed above.

\_\_\_\_\_  
Printed Name of Patient/Patient Rep & Date & Time

\_\_\_\_\_  
Signature of Patient/Patient Rep & Date & Time

# LIBERTY CARDIOTHORACIC SURGEONS

## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT'S FULL LEGAL NAME:

LAST NAME

FIRST NAME

MI

PATIENT'S ADDRESS:

I hereby acknowledge that: **LIBERTY CARDIOTHORACIC SURGEONS** has provided me a copy of its HIPAA Notice of Privacy Practices.

**DATE & TIME OF ACKNOWLEDGEMENT:**

**SIGNATURE** (Individual / Authorized Representative\*)

**PRINTED NAME**

\*If you are a personal representative signing this Acknowledgement, please provide a description of your relationship to the individual and a description of your authority to act for the individual below.

Relationship to individual

Authority to act for individual

# LIBERTY CARDIOTHORACIC SURGEONS

## PATIENT INFORMATION SHEET / REVIEW OF SYSTEMS

**TODAY'S DATE & TIME:** \_\_\_\_\_

**AGE:** \_\_\_\_\_

**PATIENTS FIRST NAME:** \_\_\_\_\_

**LAST NAME:** \_\_\_\_\_

**What brings you to our office:** \_\_\_\_\_  
\_\_\_\_\_

Who is your primary care physician: \_\_\_\_\_

Address (if known) \_\_\_\_\_

Phone number (if known) \_\_\_\_\_

Other Physicians you want records sent to: \_\_\_\_\_

### **LIST ANY ALLERGIES TO MEDICATION(S), IODINE OR X-RAY DYE**

\_\_\_\_\_  
\_\_\_\_\_

### **CURRENT MEDICATIONS (INCLUDING DOSES AND FREQUENCY)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **MEDICAL HISTORY - PLEASE LIST ANY AND ALL MEDICAL PROBLEMS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**NEUROLOGICAL / PSYCHOLOGICAL (cont.)**                      **YES**                      **NO**  
Dizziness, lightheadedness  
Feeling sad, hopeless, helpless  
Double vision, temporary blindness

**HEAD, EARS, EYES, NOSE, THROAT**                      **YES**                      **NO**  
In the past six months, have you had problems with:  
Frequent headaches  
Ringing in the ears  
Hearing loss  
Gradual loss of sharp vision  
Sudden loss of vision  
Nose bleeds  
Sinus problems  
Toothache, bleeding gums  
Difficulty swallowing  
Loss of voice  
Do you have  
Glaucoma  
Cataracts

**RESPIRATORY**    **YES**                      **NO**  
Have you had recent problems with:  
Wheezing, asthma  
Daily hacking cough  
Shortness of breath  
Coughing up blood  
Lungs filling with fluid

**CARDIAC**    **YES**                      **NO**  
In the past six months, have you had problems with:  
Chest pain  
Palpitations  
Shortness of breath with exertion  
    or climbing steps  
Sweating  
Fainting  
Hard to breathe laying flat

**VASCULAR**    **YES**                      **NO**  
In the past six months, have you had problems with:  
Leg pain with walking  
Leg swelling  
Varicose veins

**DIGESTIVE SYSTEM**    **YES**                      **NO**  
Do you have recent or on-going problems with:  
Stomach aches, indigestion, heartburn  
Getting full early in a meal  
Constipation or diarrhea

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**DIGESTIVE SYSTEM (cont.)** YES NO  
Anal or rectal pain  
Blood in stool  
Light, clay-colored stool  
Very dark urine

**GENITOURINARY SYSTEM** YES NO  
Have you had recent problems with:  
Blood in urine  
Burning while urinating  
Urinating too frequently  
Needing to urinate urgently, without  
much warning  
Weak urine stream  
Unexpected or unusually heavy vaginal  
bleeding (females)  
Impotence (males)

**MUSCULOSKELETAL SYSTEM** YES NO  
Have you had recent difficulty with:  
Bone or joint pain  
Swelling of the feet, hands, ankles and/or legs  
Calf cramping with walking  
Numbness of the feet or hands  
Non-healing sores on the legs or feet  
Chronic back or neck pain

**ENDOCRINE / METABOLIC SYSTEM** YES NO  
Have you recently noticed:  
Unexpected increase in thirst or hunger  
Jitteriness, restlessness  
Unexpected change in skin color

Do you prefer the temperature warmer or cooler than usual? \_\_\_\_\_

**HEMATOLOGIC / IMMUNOLOGIC** YES NO  
Are you aware of recent problems with:  
Anemia  
Frequent infections  
Firm lumps in the armpits, groin, or elsewhere

Have you ever had: YES NO  
Hepatitis

Cancer: Type: \_\_\_\_\_

# LIBERTY CARDIOTHORACIC SURGEONS

## MEDICAL RECORD RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ S.S.N: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

The undersigned hereby authorized the use of disclosure of the above named individual's health information as described below:

The following individual is authorized to make the disclosure:

**Physician / Clinic Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

The type and amount of information to be used or disclosed is as follows:

Two (2) years back with most recent test results

Five (5) years back with the most recent test results

Specific information: \_\_\_\_\_

**RESTRICTIONS:** Only medical records that have originated through this health care facility will be photocopies unless otherwise requested. This authorization is valid only for the release of medical information dated prior to an including the date the patient signed the authorization.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following individual or organization:

<b>To Release to:</b>	LIBERTY CARDIOTHORACIC SURGEONS
<b>Street Address:</b>	2521 GLENN HENDREN DRIVE – SUITE308
<b>City, State, Zip Code:</b>	LIBERTY, MISSOURI 64068
<b>Fax Phone #:</b>	816-407-5491
<b>For the purpose of:</b>	Medical evaluation and/or treatment

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

\_\_\_\_\_  
If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be disclosed, as provided in CRF 1640524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

\_\_\_\_\_  
**Date & Time**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Parent, Guardian, or authorized representative

\*If signed by a patient's authorized representative: \_\_\_\_\_

\_\_\_\_\_  
\*Printed name of authorized representative

\_\_\_\_\_  
\*Relationship / Capacity to patient

\_\_\_\_\_  
\*Address & telephone number of authorized representative

# LIBERTY CARDIOTHORACIC SURGEONS

## MEDICAL RECORD RELEASE OF INFORMATION TO ANOTHER INDIVIDUAL OR ORGANIZATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ S.S.N: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

The undersigned hereby authorized the use of disclosure of the above named individual's health information as described below:

The following individual is authorized to make the disclosure:

**Physician / Clinic Name:** Liberty Cardiothoracic Surgeons  
**Address:** 2521 Glenn Hendren Drive – Suite 308  
**City, State, Zip Code:** Liberty, Missouri 64068

The type and amount of information to be used or disclosed is as follows:

Two (2) years back with most recent test results

Five (5) years back with the most recent test results

Specific information: \_\_\_\_\_

**RESTRICTIONS:** Only medical records that have originated through this health care facility will be photocopies unless otherwise requested. This authorization is valid only for the release of medical information dated prior to an including the date the patient signed the authorization.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following individual or organization:

To Release to: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

\_\_\_\_\_  
If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be disclosed, as provided in CRF 1640524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

\_\_\_\_\_  
Date & Time Signature of Patient

\_\_\_\_\_  
Witness Signature of Parent, Guardian, or authorized representative

\*If signed by a patient's authorized representative: \_\_\_\_\_  
\*Printed name of authorized representative \*Relationship / Capacity to patient

\_\_\_\_\_  
\*Address & telephone number of authorized representative