Dr. Charles Lively, M.D., P.A.

Last Name: _____ First Name: _____ Mi: _____

Address: _____ City: _____ State: _____ Zip Code: _____

D.O.B: _____ Age: _____ ☐ Male ☐ Female SS#: _____

Home #: _____ Cell #: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed

Employer: _____ Work #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone #: _____

Spouse's Name: _____ Phone #: _____

Person Responsible for Account? _____

Please provide us with a valid email address so that we can give you access to a patient portal for your labs/results and prescriptions.

Email address: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone #: _____

P.O. Box: _____ City: _____ State: _____ Zip Code: _____

Policy/ID #: _____ Group #: _____ Policy Holder: _____

SS #: _____-_____-_____ D.O.B: _____ Relationship to you: _____

Note: No longer filing secondary insurances. Ask for instructions on how to file it yourself.

ASSIGNMENT & RELEASE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I, THE UNDERSIGNES CERTIFY THAT I HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO DR. LIVELY ALL INSURANCE BENEFITS, IS ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THE SIGNATURE ON ALL INSURANCE SUBMISSIONS, WHETHER MANUAL OR ELECTRONIC.

I UNDERSTAND THAT BY SIGNING BELOW THAT THIS OFFICE WILL NOT FILE MEDICAID AS SECONDARY INSURANCE.

CLINICAL INFORMATION

Please answer ALL questions, if you cannot answer the question put N/A as the answer.

Drug Allergies: _____

(please list) _____

Current Medications: _____

(please list) _____

Personal Medical History: ☐ Cardiovascular ☐ Pulmonary ☐ Gastrointestinal ☐ Musculoskeletal

☐ Neurological/Genetic ☐ Cancer ☐ Asthma ☐ Thyroid ☐ Diabetes ☐ Hypertension

☐ Other: _____

Gyn History:

How many pregnancies have you had? _____ Deliveries? _____ Abortions? _____
Miscarriages? _____

Number of Children: _____ Ages: _____

Any menstruation problems? _____

Age periods began? _____ Age at menopause? _____ 1st day of last period? _____

Last Pap? _____ Results ☐ Normal ☐Abnormal ☐ Unknown (please check one)

Last Mammo? _____ Results ☐ Normal ☐ Abnormal ☐Unknown (please check one)

Surgical History: _____

(list type & year) _____

Family History: ☐ Cardiovascular ☐ Pulmonary ☐ Gastrointestinal ☐ Musculoskeletal ☐ Neurological/Genetic

☐ Cancer ☐ Asthma ☐Thyroid ☐ Diabetes ☐ Hypertension ☐ Other: _____

Relationship to you: _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Do you drink? ☐ Yes ☐ No If yes, how much? _____

Do you use any other substances? ☐ Yes ☐ No If yes, what and how much? _____

Mental Health Issues: ☐ Mood Disorders ☐ Sleeping Problems ☐ Anxiety ☐ Other: _____

List any history of STD's that you have had: _____

What Pharmacy do you use? _____ Street: _____ City: _____

Please make sure ALL questions are answered

DR. LIVELY IS AN INVESTOR IN ODESSA REGIONAL MEDICAL CENTER AND BASIN HEALTHCARE CENTER. AT TIMES, DR. LIVELY REFERS PATIENTS TO THESE FACILITIES IN CONNECTION WITH CARE AND TREATMENT.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patients Name: _____ Date: _____

Use and disclosure of protected health information is regulated by a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Under HIPPA, providers of the healthcare are required to give patients the Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I _____ acknowledge that Charles A. Lively, M.D. has provided a written copy of its Notice of Privacy Practices for Protected Health Information to (Check One) _____ Myself or _____ specify:

_____

(If signing as a personal representative, documentation or your legal right to do so must be provided.)

_____

Signature of Patient or Personal Representative Date Printed Name Relationship to Patient (if not self)

_____

To be completed by the office of Charles A. Lively, M.D.

_____ We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____

_____

Printed Name Title Signature Date

Dr. Lively is an investor in Odessa Regional Medical Center and Basin Healthcare Center. At times, Dr. Lively refers patients to these facilities in connection with their care and treatment.

PATIENTS NAME: _____ DATE OF BIRTH: _____

IF YOU HAVE INSURANCE ONLY READ AND SIGN

PRIVATE INSURANCE ONLY

I have informed Dr. Lively's office staff that I only have private insurance, and that I have no other form of coverage. I understand that if I obtain coverage it is my responsibility to notify the office. It is the physician's discretion to file secondary insurance. **When verifying insurance, insurance companies make the statement that benefits given are not guarantee of coverage, therefore the balance could be the responsibility of the patient.**

THIS OFFICE DOES NOT FILE RETRO MEDICAID.

If private insurances are filed, I understand that any money I have paid will be applied toward all outstanding charges or balances. They will only file back to the run date and any balances remaining prior to the run date, is my responsibility to pay prior to my ending services.

Signed _____ Date _____

IF YOU HAVE NO INSURANCE READ AND SIGN

PRIVATE PAY PATIENTS

I understand that I am a private pay patient and I have no other medical coverage. I am responsible for any charges incurred and provided by my physicians. Payment will be due at time of service, unless prior arrangements have been made with the office manager. I also understand that if I apply for other assistance, it will be at the Doctor's discretion whether it will accepted and filed. In order to be provided the best quality of care, I understand Dr. Lively is limited to the number of obstetrical patients that can be accepted.

Signed _____ Date _____

Dr. Lively is an investor in Odessa Regional Medical Center and Basin Healthcare Center. At times, Dr. Lively refers patients to these facilities in connection with their care and treatment.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

FROM MEDICAL PROVIDER

I hereby authorize Dr. Lively to obtain any and all medical records concerning my care from any physician, hospital, or other health care professional that has provided medical care to me in the past.

I also authorize Dr. Lively to release any and all medical records concerning my care to any physician, hospital, or other health care professional providing care to me at any time. Additionally, I authorize Dr. Lively to release any and all medical records concerning my care to Medicare, Medicaid, and insurance company, third party administrator, or Managed Care Company.

_____ _____

Patient Signature Date

_____ _____

Printed Name Date of Birth

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBER

In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for Dr. Lively or staff to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization due to the severity of your medical condition; the law stipulates that these rules be waived.

_____ I do not authorize Dr. Lively to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize Dr. Lively to verbally release any or all information concerning my medical care to the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Patient Signature Date

May we leave a message on your answering machine or voice mail? _____

Dr. Lively is an investor in Odessa Regional Medical Center and Basin Healthcare Center. At, times Dr. Lively refers patients to these facilities in connection with their care and treatment.

HIV AND ANTIBODY CONSENT FOR TESTING

I hereby give my consent to have blood tested to find out whether or not I have antibodies to HIV in my blood. Doctors think that HIV causes Acquired Immune Deficiency Syndrome (AIDS). The reason my doctor is recommending this test is that the American Medical Association is increasingly advocating the testing for HIV for elective surgery patients. I understand that when a person is infected with a virus, the body produces antibodies, which fight the infection. If I have been infected with HIV my body may be producing the antibodies to this virus. This blood test will determine whether I have HIV antibodies. If these antibodies are present it means that I might be contagious to others. On the other hand, I have been told that a positive test does not necessarily mean I will get sick with AIDS even though I may be contagious.

I understand that sometimes the test result may be negative even though I may have been infected with the virus (false negative). This can happen because it takes time for the body to make antibodies and there may not have been enough time for the antibodies to appear before the test is performed. I understand that sometimes the test can indicate that a person has antibodies to the virus when that person is not really infected. If my test is positive for a second time it will be sent for further testing which is more confirmatory. I understand that the results of this blood test will become part of my permanent medical records at Dr. Lively's office and will only be released with my written consent.

I have read the information above and understand its contents. I have had an opportunity to ask questions which have been answered to my satisfaction. I understand that I may ask questions at any time.

Name _____ Date _____

Dr. Lively is an investor in Odessa Regional Medical Center and Basin Healthcare Center. At, times Dr. Lively refers patients to these facilities in connection with their care and treatment.

I agree that any and all claims or lawsuits arising out of or related to the medical care or healthcare and treatment I receive from Dr. Charles Lively and any of its physicians, agents, and employees shall be filled in the courts of Ector County, Texas, and any and all such lawsuits will be governed and controlled by the laws of the State of Texas, excluding any such laws that might direct the application of the laws of another jurisdiction. I agree that this paragraph applies to any suit related to my healthcare or treatment filed by myself, or any of my family members or legal representatives, alleging any injury or damage of any kind resulting from any actions or inactions of Dr. Charles Lively and any of its physicians, agents, and employees, including but not limited to any suits arising from medical treatments, lack of medical treatment or other claimed departure from accepted standards of health care, and including actions based on battery or wrongful death, and regardless of whether such claim of action sounds in tort or in contract.

Patient Signature: _____ Date: _____

riscover® cancer compass

Does cancer run in your family? Answer these questions about biological (blood) relatives on both sides of your family:

PARENTS
BROTHERS & SISTERS
HALF SIBLINGS
CHILDREN
GRANDCHILDREN
GRANDPARENTS
AUNTS & UNCLES
NIECES & NEPHEWS

PATIENT NAME _____

DATE OF BIRTH *(mm/dd/yyyy)* _____

TODAY'S DATE *(mm/dd/yy)* _____

Have you or any of your relatives had **BREAST CANCER?** NO ☐ YES ☐ →

N☐ Y☐ Do you have 2 or more relatives with any of these cancers? *(Including yourself)*
○ **BREAST CANCER** ○ **PANCREATIC CANCER** ○ **PROSTATE CANCER**

N☐ Y☐ Do you have any grandparents who are Ashkenazi Jewish?

Have you or any of your relatives been diagnosed with:

N☐ Y☐ Breast cancer at age 45 or younger?
N☐ Y☐ Male breast cancer?
N☐ Y☐ Triple negative breast cancer at age 60 or younger?
N☐ Y☐ Two different breast cancers, with the first diagnosed at age 50 or younger?

these are rare

If YES to any, fill out the other side of this form.

Have you or any of your relatives had **LYNCH SYNDROME-RELATED CANCERS?** *(see list at right)* NO ☐ YES ☐ →

N☐ Y☐ Do you have 2 or more relatives with any of these cancers? *(Including yourself)*

LYNCH SYNDROME-RELATED CANCERS

○ **COLORECTAL CANCER** ○ **SMALL BOWEL CANCER** ○ **URETER CANCER**
○ **UTERINE CANCER** ○ **BILIARY TRACT CANCER** ○ **BRAIN TUMORS**
○ **STOMACH CANCER** ○ **KIDNEY CANCER** ○ **PANCREATIC CANCER**

N☐ Y☐ Have you or any of your close relatives (parents, children, siblings) been diagnosed with colorectal or uterine cancer at age 49 or younger?

N☐ Y☐ Have you or any of your relatives been diagnosed with two different types of Lynch syndrome-related cancers (in the same person)?

If YES to any, fill out the other side of this form.

Have you or any of your relatives had **OVARIAN, FALLOPIAN TUBE,** *or* **PERITONEAL CANCER?** NO ☐ YES ☐ →

If YES, fill out the other side of this form.

If you answered **NO** to all the questions, you don't need to fill out the other side.

OFFICE USE ONLY Reviewed by: _____

Are **outlined** questions checked on front side?
☐ Yes → Turn to other side and count the cancers.
☐ No

Are **shaded** questions checked on front or back side?
☐ Yes → Patient likely meets NCCN criteria. → Patient accepted testing?
☐ No

☐ Yes Date drawn: _____
☐ No

progenity® Prepare for life.

CANCER FAMILY HISTORY

riscover® cancer compass

PATIENT NAME _____

DATE OF BIRTH *(mm/dd/yyyy)* _____

Complete this side if you have relatives with these cancers only

○ BREAST ○ OVARIAN ○ LYNCH SYNDROME-RELATED CANCERS
○ PANCREATIC ○ FALLOPIAN TUBE ○ PERITONEAL COLORECTAL UTERINE STOMACH SMALL BOWEL BILIARY TRACT KIDNEY URETER BRAIN TUMORS
○ PROSTATE

If you have more affected relatives, use the "other" space in each category.

***AVAILABLE TO TEST?**

Tell us if affected relatives are available for testing by writing the appropriate letter code in the box.

N Unavailable due to personal reasons **E** Estranged; unable to contact
D Deceased **Y** Available for testing

Some health plans require this information to determine eligibility.

Relatives on your mother's side

MOTHER
Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

MATERNAL AUNT/UNCLE
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

MATERNAL AUNT/UNCLE
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

MATERNAL GRANDMOTHER
Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

MATERNAL GRANDFATHER
Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ PROSTATE

OTHER MATERNAL *relationship:*
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

Relatives on your father's side

FATHER
Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ PROSTATE

PATERNAL AUNT/UNCLE
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

PATERNAL AUNT/UNCLE
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

PATERNAL GRANDMOTHER
Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL

PATERNAL GRANDFATHER
Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ PROSTATE

OTHER PATERNAL *relationship:*
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

Relatives that belong to both your mother's and father's sides

YOU
☐ Female ☐ Male Age diagnosed:
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR CHILD
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR GRANDCHILD
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR SIBLING
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

YOUR NIECE/NEPHEW
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

OTHER *relationship:*
☐ Female ☐ Male Age diagnosed: Available to test?* ▼
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* Choose one
○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE

OFFICE USE ONLY

If outlined questions are checked on the front, count the affected relatives on the **same side of the family**.

Relatives in the bottom category (**YOU, YOUR SIBLING,** etc.) count on **both sides of the family.**

N☐ Y☐ 3 people on the **same side of the family** with ✓**BREAST,** ✓**PANCREATIC,** or ✓**PROSTATE CANCER?**

N☐ Y☐ 2 people on the **same side of the family** with ✓**BREAST,** ✓**PANCREATIC,** or ✓**PROSTATE CANCER,** with one person diagnosed with breast cancer at age 50 or younger?

N☐ Y☐ 3 people on the **same side of the family** with ✓**LYNCH-RELATED** or ✓**PANCREATIC CANCER?**

N☐ Y☐ 2 people on the **same side of the family** with ✓**LYNCH-RELATED** or ✓**PANCREATIC CANCER** with one person diagnosed at age 49 or younger?

Dr. Charles A. Lively, M.D.

Total Gynecological Health for Women

You are here for your Annual Exam, which includes your Pap Smear. Listed below are some optional tests that you may want to add on. These tests are billed seperatley by the pathology company "Avero". Avero is not associated financially with this practice. The pathology company will bill your insurance and you directly.

Please check any additional testing you would like:

_____ HPV Testing

(This is the virus that may cause cervical, vulvar, anal, and rectal cancer and/or warts in these areas)

_____ Sexually Transmitted Disease Panel

(Includes: Gonorrhea, Chlamydia, Trichomonas)

_____ Bacterial Vaginosis / Yeast Panel

By signing below I understand that I may receive additional charges from the pathology company "Avero". Insurance may not cover these additional test and you would then receive a bill from the pathology company "Avero". Any questions or concerns regarding charges/balances will be handled through the pathology company Avero's customer service department at (877) 771-2018.

_____ _____

Patient Signature Date

HRT CHECKLIST FOR WOMEN

Name: _____ Date: _____

Email: _____

Symptom (please check mark)

	NEVER	MILD	MODERATE	SEVERE
Depressive mood				
Fatigue				
Memory Loss				
Mental Confusion				
Decreased sex drive/libido				
Sleep Problems				
Mood Changes/Irritability				
Tension				
Migraine/Severe Headaches				
Difficult to climax sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry and Wrinkled Skin				
Hair is falling out				
Cold all the time				
Swelling all over the body				
Joint Pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimers' Disease		
Breast Cancer		