LylesMD
Personalized Health Care

Patient Registration Form

Date:_____

Full Name:	**Last**	**First**	**Middle**	**(Maiden)**
Address: (Street or Box)		**City**	**State**	**Zip**
Home Phone #	**Work Phone #**	**Cell Phone #**	**Email Address**	
Date of Birth	**Age**	**Gender** ☐ Male ☐ Female	**Driver's License # / State**	
Marital Status (check one) ☐Single ☐Married ☐Widowed ☐Divorced ☐ Separated		**Spouse's Name (if applicable)**		
Occupation	**Employer**	**Employer's Address**		
If patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation may be required)				
Emergency Contact (not living at the same address)		**Relationship to Patient**		
City	**State**	**Zip**	**Phone**	
How did you hear about the Viverae Care Center? ☐Existing Patient (Dr. Boyd Lyles) ☐Website/Internet ☐Family/Friend (Who?) ☐Physician (Who?)				

Pharmacy Information

Preferred Pharmacy	Address or Major intersection	Telephone Number

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Financial Responsibility Authorization

I hereby authorize payment of medical benefits directly to Viverae Care Center, Inc. (hereinafter "VCC") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim and/or payment. I understand that this authorization may include release of information regarding mental health conditions or communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered, which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to VCC. I understand there will be a fee for any electronic correspondence anytime with Dr. Lyles as well as afterhours phone calls. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of VCC, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this authorization, I am responsible for payment of services in full before the services are rendered.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

_____

Please print name (if different from patient name below)

_____

Patient name

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Consent & Waiver

To the Patient

By participating in the Viverae Care Center ("VCC") programs, you have the right to be given information about VCC Services (defined below) and the risks and hazards of these Services. The purpose of this Consent and Waiver form is to provide you with this information and to obtain your consent to the Services provided by VCC.

To the Patient's Parent, Legal Guardian, or Managing Conservator

As the parent, legal guardian, or managing conservator of a child, you have the right to be given information about the Services provided by VCC to your child or ward and the risks and hazards associated with those Services. You are also required to provide written consent, or permission, for these Services as provided in this Consent and Waiver form. A child includes each person who is under 18 years old, unmarried, and has not had the disabilities of minority removed by court order.

I do hereby voluntarily consent to and request to have health screening and diagnostic testing performed on me by VCC. This may include, but is not limited to, (i) having my blood drawn, (ii) giving a urine specimen, and (iii) participating in: various stress tests (including a treadmill stress test); vision, hearing and heel bone density testing; psychological screening; nutritional consultations; phone and internet coaching; lung capacity testing; heart echocardiograms; and medical evaluations (collectively referred to as the "Services"). I give my permission to the VCC doctors, physician assistants, nurses, technical assistants, and other healthcare professionals, employees, volunteers and contractors to provide the Services.

Risks and Hazards of the Services

Although it is rare that an individual is harmed by the Services performed by VCC. I have been informed by VCC and understand that the risks and hazards that may occur to me as the result of the Services include, but are not limited to: infection from the drawing of blood, heart complications or cardiac arrest from a stress test, sprained ankle or bodily injury from a treadmill stress test, and lung irritation from the lung capacity test.

In accepting these screening tests and assessments, I hereby waive all claims against VCC, its respective owners, employees, affiliates, consultants, advisors, agents, volunteers, and/or health professionals with regard to acts performed and Services rendered, statements made, or results reported to me in connection with the health screening tests and assessments. I further release VCC, its respective owners, employees, affiliates, consultants, advisors, agents, volunteers, and/or health professionals, from any and all liability, including any matter concerning any follow-up examination. My signature below indicates that I have read and fully understand this Waiver and Consent. I hereby give my permission and consent for VCC to provide myself or, as applicable, my child or ward with the Services.

I certify that I have read and fully understand this Consent and Waiver form and certify that no guarantee or assurance has been made to me concerning the results or follow-up of the Services. My signature below indicates that I have read and fully understand this Waiver and Consent. I hereby give my permission and consent for VCC to provide myself or, as applicable, my child or ward with the Services.

_____	_____	_____
Signature of Patient (if over 12, must sign)	**Printed Name of Patient (if over 12, must sign)**	**Date**
_____	_____	_____
Signature of Parent/Guardian (if applicable)	**Printed Name of Parent/Guardian (if applicable)**	**Date**
_____	_____	
Witness Signature	**Date**	

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Authorization for Release of Health Information

To:

I hereby voluntarily authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization") to **Dr. Boyd D. Lyles**, and any of his/her authorized agents and/or any other personal representatives ("Authorized Recipients").

Individual's Full Legal Name:_____ **[Please Print]**

DOB_____/_____/_____**[mm/dd/yyyy]** **Contact Number (**_____**)**_____**-** _____

Please send the requested information to:
LylesMD
12810 Hillcrest Rd, Ste. B129
Dallas, TX 75230
Phone (469) 398-3398
Fax (469) 916-1824

Specific description of Protected Health Information to be used or disclosed to Authorized Recipients:

Complete Medical Record (Entire Chart)

The Protected Health Information is being released at my request for the purpose of the Authorized Recipient's information and use in connection with my coordination of health care.

Expiration Event: This Authorization will expire when LylesMD is no longer contractually obligated to provide services to my employer or me.

I understand that I may refuse to sign this Authorization, and that my health care treatment, payment, enrollment or eligibility for benefits under my health plan will not be conditioned upon signing this form. I also understand that my Protected Health Information is subject to re-disclosure by the Authorized Recipients of the Protected Health Information pursuant to this Authorization and that, once released, the Protected Health Information may no longer be protected by federal privacy regulations. I also understand that I may revoke this Authorization at any time by notifying the Authorized Recipients in writing, but if I do, the revocation will not have any effect on any actions the Authorized Recipients took before the receipt of the revocation of this Authorization.

(Form MUST be completed before signing)

_____ _____

Signature of individual or individual's representative **Date**

If applicable, printed name of individual's representative: _____
Relationship to, or authority to act for, the individual: _____

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Medicare Opt-Out Contract

This agreement is between Boyd D. Lyles, M.D. ("Physician"), whose principal place of business is 12810 Hillcrest Rd., Ste B129, Dallas, TX 75230, and_____("Patient"), who resides at_____ _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B, pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on_____for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the"Services"):

- Physical Exams
- Non-urgent healthcare

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) tothe Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available tohim/her.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on: _____ by: _____

_____ _____
Patient name Patient signature

_____ _____
Physician name Physician signature

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New Patient

Appointment Date _____

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Emergency Contact _____ Relationship _____

Contact's Phone _____

Physicians seen:	Reason seen:

Your health concerns at this time:	When symptoms/concern began:

Current Prescription Medications:	Dose:

Medication Allergies:	Reaction (rash, breathing, etc.):

Vitamins and Supplements you are now taking:

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Family Health

	Age If Living	Age Deceased	Chronic Health Problems
Mother			
Father			
Brother or Sister			
Brother or Sister			
Brother or Sister			
Ages of Children			

Past Medical History

Where you healthy as a child?_____ Did you miss much school for illness? _____

Any unusual or serious childhood diseases? _____

Have you broken any bones (fractures)? _____ If yes, which ones? _____

Have you ever had a concussion (head injury)? _____ If yes, when (year)? _____

Past surgeries (and year) _____

_____

_____

Hospitalizations other than the above surgeries (and year) _____

_____

Have you recently experienced problems with any of the following?

	Yes	No	If yes, please explain
Loss of energy?	☐	☐	_____
Difficulty sleeping?	☐	☐	_____
Chest or heart symptoms?	☐	☐	_____
Eye problems?	☐	☐	_____
Ear, nose or throat?	☐	☐	_____
Lung or breathing?	☐	☐	_____
Stomach or bowel?	☐	☐	_____
Urinary symptoms?	☐	☐	_____
Bone, joint or muscle?	☐	☐	_____
Headache or numbness?	☐	☐	_____
Bruising or bleeding?	☐	☐	_____
Pelvic/sexual problems?	☐	☐	_____

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Diet and Nutrition (please just estimate a "typical" day)

Usual Breakfast _____
Usual Lunch _____
Usual Dinner _____
Snacks_____ Alcohol Servings per Week_____

Current Exercise:	**Frequency:**
_____	_____
_____	_____
_____	_____
_____	_____

Have you smoked/used tobacco in the past 10 years? No_____Yes_____

Type? _____

How many nights per month do you travel and are away from home? _____

Any international trips planned in the coming year? _____

If yes, the destination? _____

Most recent Tetanus vaccination?_____(Recommended every 10 years)

Most recent colonoscopy? _____

How is your current exposure to stress? High_____Moderate_____Low _____

How is your anxiety level? High_____Moderate_____Low _____

Do you have any concerns about being depressed? No_____Yes _____

Do you have a hobby? _____

Do you have a Living Will? _____

Do you feel safe in your environment? (if no, please explain)_____

Health questions/concerns that you would like to have addressed: _____

_____

_____

Thank you.

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Your "Bucket List"

Name _____

Although known about for years, the "bucket list" concept was popularized by the 2007 movie of the same name, starring Jack Nicholson and Morgan Freeman. What is known is that formulating such a list of personal goals can be helpful in refocusing and prioritizing your time and efforts. It can be both fun and rewarding if you haven't updated your list recently, and on a more sober note, can help you achieve some of your suppressed desires during the short time we have on this planet. Take a few minutes and complete the following. We think it will be both enlightening and helpful in your overall quest for well-being and life satisfaction.

A couple of tips on completing your list: make sure to include childhood dreams—focus on activities or relationships rather than things and items that you realistically feel you would do. Rank them either in order of importance or in order of likelihood.

Date completed _____

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

If you have not watched it yet, you might want to take in the video, "The Last Lecture" (2007) by Randy Pausch of Carnegie Mellon University, on YouTube. It is time (76 minutes) well spent and a heartfelt lesson from someone who really understood the value of the bucket list.

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Patient's name:_____ Date:_____

Please carefully read each item in the list. Indicate how much you have experienced the symptom listed by checking the box in the corresponding space in the column next to each symptom.

I-PPS	None	Rarely	Half the time	Frequently	Chronic
Incomplete emptying: Over the last month, how often have you had the sensation of not emptying your bladder completely after urinating?	☐	☐	☐	☐	☐
Frequency: Over the past month, how often have you had to urinate again less than 2 hours after urinating?	☐	☐	☐	☐	☐
Intermittency: Over the past month, how often have you found that you stopped and started again several times when you urinate?	☐	☐	☐	☐	☐
Urgency: Over the past month, how many times have you found it difficult to postpone urination?	☐	☐	☐	☐	☐
Weak Stream: Over the past month, how often have you had a weak stream?	☐	☐	☐	☐	☐
Straining: Over the past month, how often have you had to push or strain to begin urination?	☐	☐	☐	☐	☐
Nocturia: Over the past month, how many times did you most typically get up to urinate, from the time you went to bed until the time you got up in the morning?	☐	☐	☐	☐	☐

TOTAL SCORE: (add the numbers you have circled): AUA SCORE _____

If you were to spend the rest of your life with your urinary condition just the way it is today, how would you feel about that?

☐Delight ☐Pleased ☐Mostly Satisfied ☐Mixed Feelings ☐Mostly Dissatisfied

☐Unhappy ☐Terrible

1. Are you able to have erections?_____ Are they adequate for intercourse?_____
2. Are you sexually active? _____
3. If you have already had treatment for prostate cancer, have you noticed a change in your potency since then?_____ If yes, please explain_____
4. Have you noted any blood with your bowel movements? _____
   If yes, please explain _____

Has this ever been addressed? _____